MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00100

REPLACEMENT: 6210 2-5-57 - Dr. Lovitt

Reg. Dist. No. 132

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Friendship
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
   a. STATE: Md.
   b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Friendship
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: William — Middle: Thomas — Last: Armiger

4. DATE OF DEATH: Month: Jan. — Day: 1, — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/11/97

9. AGE (In years last birthday): 59 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Building

11. BIRTHPLACE (State or foreign country): Friendship

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: JOSEPH F. ARMIGER

14. MOTHER'S MAIDEN NAME: AGNES V. ATWELL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): WW 1

16. SOCIAL SECURITY NO.: none

17. INFORMANT — Address: AGNES V. ARMIGER 212 Cedar drive DC 22

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarct due to hypertensive arteriosclerotic cardiovascular disease
443 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour: a. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED — While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Willis V. Lovitt M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): William V. Lovitt, Jr., M.D.

DATE SIGNED: 2/6/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1/6/57

22c. NAME OF CEMETERY OR CREMATORY: Union Chapel

22d. LOCATION (City, town, or county) (State): McKendree Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: BERNARD HARDESTY GALESVILLE MD.

24a. REC'D BY REGISTRAR — DATE: 1/10/57

24b. REGISTRAR'S SIGNATURE: WM. J. FRENCH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

133 **CERTIFICATE OF DEATH** 00101

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Baltimore City

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville

c. LENGTH OF STAY IN 1b: 1yr.9mos.2days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 3 Yrs 4 2637 France Street

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

d. STREET ADDRESS: Baltimore City

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Thomas Middle: Last: Banks

4. DATE OF DEATH: Month: 1 Day: 3 Year: 1957

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Not given

9. AGE (In years last birthday): 67? yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY: Unk.

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Solomon Banks

14. MOTHER'S MAIDEN NAME: Mary Banks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service): Unk.

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records Address: Crownsville State Hospital Crownsville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH

420.0

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Hypertensive, arteriosclerotic heart disease

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypostatic Pneumonia

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12/24, 19 56 to 1/3, 19 57, that I last saw the deceased alive on 1/3, 19 57, and that death occurred at 10:40a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D. ADDRESS (Street, city or town, state): Crownsville, Md. DATE SIGNED: 1/3/57

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp

22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 1-5-57 22c. NAME OF CEMETERY OR CREMATORY Mt Olivet 22d. LOCATION (City, town, or county) (State) Baltimore

23. FUNERAL DIRECTOR'S SIGNATURE: E. O. Wilson ADDRESS

24a. REC'D BY REGISTRAR DATE 1/18/57 24b. REGISTRAR'S SIGNATURE: K. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00102

134

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G. Meade
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Army Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 21201-4
d. STREET ADDRESS: 1323 West Mountroyal Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First TIMOTHY — Middle (NMN) — Last BEISEL

4. DATE OF DEATH: Month January — Day 30 — Year 19 57

5. SEX: Male

6. COLOR OR RACE: Cau

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 17 March 1895

9. AGE (In years last birthday): 61 yrs. — IF UNDER 1 YEAR: Months 10 Days 13 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier

10b. KIND OF BUSINESS OR INDUSTRY: U. S. Army

11. BIRTHPLACE (State or foreign country): Hazelton, Pennsylvania

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): Present

16. SOCIAL SECURITY NO.:

17. INFORMANT: U.S. Army Ft. Meade Md — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Several yrs

421.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Calcific Aortic Stenosis — II

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10 Jan 19 57, to 30 Jan 19 57, that I last saw the deceased alive on 30 Jan 19 57, and that death occurred at 1230P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John F. McDonnell Jr. M.D. — ADDRESS (Street, city or town, state): U. S. ARMY HOSPITAL — DATE SIGNED: 30 Jan 57

PHYSICIAN'S NAME (Type): JOHN F. McDONNELL, M.D., MAJ., MC. — Fort George G. Meade, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1-4-57

22c. NAME OF CEMETERY OR CREMATORY: Arlington

22d. LOCATION (City, town, or county) (State): Wash D-C

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: WILLIAM COOKE, Inc. Baltimore, Maryland

24a. REC'D BY REGISTRAR — DATE: 30 Jan 57

24b. REGISTRAR'S SIGNATURE: W. L. SAYLOR, 1ST LT, MSC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00103

Reg. Dist. No. 135

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Linthicum
c. LENGTH OF STAY IN 1b: 7 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 407 W. Maple Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Linthicum
d. STREET ADDRESS: 407 W. Maple Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle H. — Last BLANDIN

4. DATE OF DEATH: Month January — Day 16 — Year 1957

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 15/1905

9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Elec. Maintanance

10b. KIND OF BUSINESS OR INDUSTRY: Friendship Airport.

11. BIRTHPLACE (State or foreign country): Kansas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Clark W. Blandin

14. MOTHER'S MAIDEN NAME: Gertrude E. Hart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): '26-'30

16. SOCIAL SECURITY NO.: 214 01 5939

17. INFORMANT: Mrs. Alice M. Blandin — Address: Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Pancreas
157X
DUE TO
(b): with Mestastasis
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 6 mo. plus

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 31/ 1956, to Jan. 16/ 1957, that I last saw the deceased alive on Jan. 16/ 1957, and that death occurred at 6:P.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: C. Milton Linthicum M.D. — ADDRESS (Street, city or town, state): 106 W. Maple Rd. — DATE SIGNED

PHYSICIAN'S NAME (Type): C. Milton Linthicum — Linthicum Heights, Md. — 1/17/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Jan. 19/57

22c. NAME OF CEMETERY OR CREMATORY: Glen Haven

22d. LOCATION (City, town, or county) (State): Glen Burnie, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: D. Leighton — ADDRESS: Glen Burnie, Md.

24a. REC'D BY REGISTRAR DATE: JAN 21 1957

24b. REGISTRAR'S SIGNATURE: A. H. Edwards

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00104

Reg. Dist. No. 136

1. PLACE OF DEATH
a. COUNTY A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cape Lock Haven
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Poplar + Oak Aves

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Md. b. COUNTY A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cape Lock Haven
d. STREET ADDRESS Poplar & Oak Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Eula Middle G. Last Bohn

4. DATE OF DEATH Month 1 Day 24 Year 1957

5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 8. DATE OF BIRTH Oct 8-1893 | 9. AGE (In years last birthday) 63 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Rave Springs Va.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME William McCray
14. MOTHER'S MAIDEN NAME Adaline Moody

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO.
17. INFORMANT Joseph H. Fisher Address (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Disease — INTERVAL BETWEEN ONSET AND DEATH Sudden
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE OF M.D. Thos Tuff
EXAMINER'S NAME (Type) A Linhardt
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 1/24/57

22a. BURIAL, CREMATION, REMOVAL (Specify) Removal
22b. DATE THEREOF 1-25-57
22c. NAME OF CEMETERY OR CREMATORY Fair View
22d. LOCATION (City, town, or county) (State) Roanoke Va

23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons
ADDRESS Annapolis Md
24a. REC'D BY REGISTRAR DATE 1/29/57
24b. REGISTRAR'S SIGNATURE —

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00105

CERTIFICATE OF DEATH

100

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 82 MARKET St.

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: MD
b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
d. STREET ADDRESS: 82 MARKET St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle L Last BOUCHER

4. DATE OF DEATH: Month 1 Day 22 Year 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-21-1893

9. AGE (In years last birthday): 63 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Court Crier Md.

10b. KIND OF BUSINESS OR INDUSTRY: Court of Appeals

11. BIRTHPLACE (State or foreign country): ANNAPOLIS MD

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: WILLIAM MOSS BOUCHER

14. MOTHER'S MAIDEN NAME: ROSE McBEE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) World War I

16. SOCIAL SECURITY NO.:

17. INFORMANT: LOTTIE REVELL Address Annapolis Md 812 CHESAPEAKE AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Hrs

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic heart disease — 1 yr

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour o m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 20, 1956 to Jan 23, 1957 that I last saw the deceased alive on Jan 23, 1957, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James R. Martin M.D. ADDRESS (Street, city or town, state): 6 Shaw St. Annapolis, Md. DATE SIGNED: 1/24/57

PHYSICIAN'S NAME (Type): JAMES R. MARTIN 6 SHAW ST. ANNAPOLIS, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1-26-57

22c. NAME OF CEMETERY OR CREMATORY: St Mary's

22d. LOCATION (City, town, or county) (State): Annapolis Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M Taylor Sons ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR DATE: 1/24/57

24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00106

Reg. Dist. No. 101

1. PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 608 Glendon Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: A A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
d. STREET ADDRESS: 608 GLENDON Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARRY — Middle C — Last BROWN

4. DATE OF DEATH: Month JAN — Day 14 — Year 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 7-4-1878

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WATCHMAN (STATE)

10b. KIND OF BUSINESS OR INDUSTRY: WATCHMAN

11. BIRTHPLACE (State or foreign country): COCKEYSVILLE Md

12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: Charles E. Brown

14. MOTHER'S MAIDEN NAME: Priscilla Gill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Naomi Marcott — Address (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gun Shot wound Neck
DUE TO
(b)
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

776 X

INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Self Inflicted Gun Shot Wound

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D.
EXAMINER'S NAME (Type): E. LINHARDT

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 1/15/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jany 17-57
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest
22d. LOCATION (City, town, or county) (State): Annapolis Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons
ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR / DATE: 10/16/57
24b. REGISTRAR'S SIGNATURE: C. Brunck

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. AISME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00107

CERTIFICATE OF DEATH

102

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: a. Parkney St.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 29 Parkney
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First William Middle H Last Brown
4. DATE OF DEATH: Month 1 Day 25 Year 1957
5. SEX: Male
6. COLOR OR RACE: Cal
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-15-1887
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months 10 Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: City of Anna.
11. BIRTHPLACE (State or foreign country): Biddsville Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Benjamin Brown
14. MOTHER'S MAIDEN NAME: Elizabeth Foote

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO:
17. INFORMANT: Agnes Brown — Address: Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-4-57, 19____, to 1-25-57, 19____, that I last saw the deceased alive on 1-23-57, 19____, and that death occurred at 4:45 M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state): 6 L Gotland St
DATE SIGNED
ACTUAL SIGNATURE: A. T. Allen M.D.
PHYSICIAN'S NAME (Type): A T ALLEN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-29-57
22c. NAME OF CEMETERY OR CREMATORY: Brewer Hill
22d. LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese
ADDRESS: Annapolis, Md
24a. REC'D BY REGISTRAR DATE: 1-29-57
24b. REGISTRAR'S SIGNATURE: Wm. J. Lynch

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00109

Reg. Dist. No. 21

103

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DOA Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Churchton
d. STREET ADDRESS: Dudley Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle WOOD W Last CHAPMAN

4. DATE OF DEATH: Month January Day 17 Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 3, 1913
9. AGE (In years last birthday): 43 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mach.
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov
11. BIRTHPLACE (State or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Clarence Chapman
14. MOTHER'S MAIDEN NAME: Rose Carmeon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: Mrs. C.W. Chapman - Wife- Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary disease — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour 7:40 a.m. Month, Day, Year Jan 17 1957
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: January 17, 1957
EXAMINER'S NAME (Type): Elmer G. Linhardt MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: January 21,57
22c. NAME OF CEMETERY OR CREMATORY: Mt. Hebron Comet,
22d. LOCATION (City, town, or county) (State): Winchester, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: [signature]
ADDRESS: Annapolis, Maryland
24a. REC'D BY REGISTRAR DATE: JAN 21 1957
24b. REGISTRAR'S SIGNATURE: Wm. J. French

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P.M.3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00110

Reg. Dist. No. 137

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jessups
c. LENGTH OF STAY IN 1b: Few seconds
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 2000 Feet east of route 8 1/2 5

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): N. Fort Meade
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edward — Middle: — Last: Collins

4. DATE OF DEATH: Month: January — Day: 21st, — Year: 1957

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/6/28

9. AGE (In years last birthday): 28

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sergeant in the U.S. Army

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Gilbert, S. Carolina.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes at present.

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Fort Meade Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fracture of skull — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Comp. comm. fracture of left forearm — Sudden

DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Automobile hit a telephone post and turned over.

20c. TIME OF INJURY: Hour: 1.55 A.M. P.M. — Month, Day, Year: 1/21/57 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.): Route 8 Md.

20f. (City or town) Jessups (County) A.A. (State) Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gustave H Faubert M.D. — DATE SIGNED

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Gustave H. Faubert, M.D. — 1/21/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 1-27-57 — 22c. NAME OF CEMETERY OR CREMATORY: Palmetta Cemetery — 22d. LOCATION (City, town, or county) (State): Columbia, S. C.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Arlington S. Phillips, 1808 N. Monroe St. Baltimore, Md

24a. REC'D BY REGISTRAR — DATE: 21 Jan 57 — 24b. REGISTRAR'S SIGNATURE: W. L. SAYLOR, 1/Lt MSC

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 0209 1-21-57 es

104

CERTIFICATE OF DEATH

00111

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY A. A. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE Md
b. COUNTY A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Broad Neck
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print) First Virginia Middle Last Castle

4. DATE OF DEATH Month Jan Day 7 Year 19 57

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH April 17 1900
9 AGE (In years last birthday) 56 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (State or foreign country) V
12 CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME William Castle
14. MOTHER'S MAIDEN NAME Alice Hancock

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17 INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac. Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH Instant
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Cardio Vascular
DUE TO (c) disease & Hypertension — yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Extreme Decompensation
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/2 19 57 to 1/8 19 57 that I last saw the deceased alive on 1/7 19 57, and that death occurred at 7 A M, from the causes and on the date stated above.
ACTUAL SIGNATURE Maurice F. Klawans M.D. ADDRESS (Street, city or town, state) 3 Gentry Gate Dr Annapolis Md DATE SIGNED 1/10/57
PHYSICIAN'S NAME (Type) MAURICE F. KLAWANS

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF
22c. NAME OF CEMETERY OR CREMATORY
22d. LOCATION (City, town, or county) (State)

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
24a. REGISTRAR DATE JAN 15 1957
24b. REGISTRAR'S SIGNATURE Wm J. French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00112

138

1. PLACE OF DEATH a. COUNTY A. A. Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEAVERDAM BEACH
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CADLE AVE

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE MD. b. COUNTY A. A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEVERLY BEACH
d. STREET ADDRESS CADLE AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First JAMES Middle EDWIN Last CORPREW
4. DATE OF DEATH Month 1 Day 26 Year 1957

5. SEX M
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 2-13-1873
9. AGE (In years last birthday) 83 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CIVIL SERVICE
10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't.
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME "U.NK"
14. MOTHER'S MAIDEN NAME "UNK"

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I
16. SOCIAL SECURITY NO.
17. INFORMANT Address MARY PEARL CORPREW #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Disease — Interval between onset and death: Sudden
DUE TO (b)
434.3
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined couse ☐.

ACTUAL SIGNATURE [signature] M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
NAME (Type) G. LINHARDT
DATE SIGNED 1/26/57

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 1-30-57
22c. NAME OF CEMETERY OR CREMATORY LOUDON PARK
22d. LOCATION (City, town, or county) BALTIMORE (State) MD

23. FUNERAL DIRECTOR'S SIGNATURE John M Taylor & Son ADDRESS Annapolis, Md.
24a. REC'D BY REGISTRAR, DATE 1/29/57
24b. REGISTRAR'S SIGNATURE [signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

105

00113

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S.Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md — b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis,
d. STREET ADDRESS: 90 Duke of Gloucester St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Eleanore — Middle: Ridout — Last: DASHIELL

4. DATE OF DEATH: Month: January — Day: 17 — Year: 1957

5. SEX: F

6. COLOR OR RACE: Cau

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-8-1866

9. AGE (In years last birthday): 90 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: DOMESTIC

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Wrems Ridout

14. MOTHER'S MAIDEN NAME: Elizabeth Beaman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: U.S.N.H. Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Infarction, myocardium — INTERVAL BETWEEN ONSET AND DEATH: 24 hours
420.1
DUE TO (b): Coronary Artery insufficiency
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pyelonephritis, acute, right.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-16, 1957, to 1-17-57, 1957, that I last saw the deceased alive on 1-17-57, 1957, and that death occurred at 1810 / 6:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Vincent P. Butler, Jr. M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED: 1-18-57

PHYSICIAN'S NAME (Type): V.P.Butler Jr LT MC USN

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 1-21-57
22c. NAME OF CEMETERY OR CREMATORY: US NAVAL ACADEMY CEM
22d LOCATION (City, town, or county): ANNAPOLIS (State): MD.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: JOHN M. TAYLOR SON ANNAPOLIS MD

24a. REC'D BY REGISTRAR DATE: 1/21/57

24b REGISTRAR'S SIGNATURE: J. A. Council

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00114

139

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ferndale
c. LENGTH OF STAY IN 1b: 6 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 104 111 Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Same — b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Same
d. STREET ADDRESS: Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clarence — Middle: Wilbur — Last: Deardoff

4. DATE OF DEATH: Month: january — Day: 15th. — Year: 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/12/1903

9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Lt. Commander in the Coast Guard

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Dayton, Ohio

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Deardoff

14. MOTHER'S MAIDEN NAME: Carrie McGrew

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes Army and Navy. WW1

16. SOCIAL SECURITY NO.: 218 36 3007

17. INFORMANT — Address: Mrs. Harriett Deardoff (wife).

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO (b): Cirrhosis of the liver — 4 y.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 581.0

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gustave H. Faubert M.D. M.D. — DATE SIGNED

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Gustave H. Faubert, M.D. — January 16 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 18 Jan'57
22c. NAME OF CEMETERY OR CREMATORY: Balto. National Cem.
22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Richard P. Wright
ADDRESS: Glen Burnie, Md.

24a. REC'D BY REGISTRAR DATE: JAN 18 1957

24b. REGISTRAR'S SIGNATURE: L. J. Dallas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 9M3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00115

140

CERTIFICATE OF DEATH

Reg. Dist. No. 7-F

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 39 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 422 Crain Highway S.W.

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d STREET ADDRESS: 422 Crain Highway S.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Daniel Middle Peter Last Donnelly

4. DATE OF DEATH: Month Jan. Day 31 Year 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 23, 1877

9. AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Policeman (ret)

10b. KIND OF BUSINESS OR INDUSTRY: A.A.Co. Police

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service): ----------

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. John F. Donnelly — Address: 508 Glenview Ave. Glen Burnie, Md

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Uremia — ?
DUE TO
(c): Hypertension — 3 y.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Myocardial insufficiency

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 19 55 to 2/1/57 19 ____, that I last saw the deceased alive on 1/20th. 1957 19 ____, and that death occurred at 7.45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Gustave H. Faubert M.D. — ADDRESS (Street, city or town, state): Glen Burnie, Md. — DATE SIGNED: 1 Feb. 1957

PHYSICIAN'S NAME (Type): Gustave H. Faubert, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 4. 1957

22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cemetery

22d LOCATION (City, town, or county) (State): Glen Burnie, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Richard V. Singleton — ADDRESS: Glen Burnie, Md.

24a. REC'D BY REGISTRAR — DATE: FEB 5 1957

24b. REGISTRAR'S SIGNATURE: L. J. Tebbs

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

106

Reg. Dist. No. 00116

1. PLACE OF DEATH
a. COUNTY Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town). Crownsville
c. LENGTH OF STAY IN 1b: 3 wks.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland — b. COUNTY Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater, Maryland
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES Middle S. Lost DOVE

4. DATE OF DEATH: Month JAN Day 24 Year 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov 3 1880

9. AGE (In years last birthday): 76 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY: Tobacco

11. BIRTHPLACE (State or foreign country): McKendree Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES T Dove

14. MOTHER'S MAIDEN NAME: Laura E Sherbert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None.

17. INFORMANT: JAMES A Dove — Address: Shadyside Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized Peritonitis - (2) Fistulae — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b): Small bowel (Post operative) 20 days — 20 days
DUE TO
(c): Perforation of small bowel - mesenteric thrombosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 3, 1957, to Jan 24, 1957, that I last saw the deceased alive on Jan 24, 1957, and that death occurred at 3:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: C Kuhlhardt M.D.
ADDRESS (Street, city or town, state): Chesapeake Beach Md
DATE SIGNED: 1/24/57
PHYSICIAN'S NAME (Type): E. Kuhlhardt.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/26/57
22c. NAME OF CEMETERY OR CREMATORY: Mt Zion
22d. LOCATION (City, town, or county) (State): Lothian Md

23. FUNERAL DIRECTOR'S SIGNATURE: Burnard Henderson
ADDRESS: Galesville Md

24a. REC'D BY REGISTRAR DATE: 1/29/57
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00117

107

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A A General

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md.
b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 221 Gloucester
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DOUGHLAS Middle FOREST Last DUVAL

4. DATE OF DEATH: Month 1 Day 16 Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-4-1870

9. AGE (In years last birthday): 86 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Col U.S.A Ret

10b. KIND OF BUSINESS OR INDUSTRY: Col. U.S.A Ret

11. BIRTHPLACE (State or foreign country): Montgomery Co Md

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Edmund Peyton Duval

14. MOTHER'S MAIDEN NAME: Marion Lee Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT (Address): Mrs Wm Randall Sayles (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Paralytic Ileus — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs
DUE TO (b): Perforated Viscus — 48 hrs
DUE TO (c):

10.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-16-, 1952, to 1-16-, 1952 that I last saw the deceased alive on 1-16-, 1957, and that death occurred at 3:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE, M.D.: Donald A. Martin — ADDRESS (Street, city or town, state): 68 Law St. Annapolis, Md. — DATE SIGNED: 1/18/57

PHYSICIAN'S NAME (Type): JAMES R. MARTIN — ANNAPOLIS, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1-19-57

22c. NAME OF CEMETERY OR CREMATORY: St Anns

22d. LOCATION (City, town, or county) (State): Annapolis Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Sayles Sons — ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR DATE: 10/18/57

24b. REGISTRAR'S SIGNATURE: Wm. J. French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

108

00118

Reg. Dist. No. 29

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN 1b Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 23 Lee St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland COUNTY A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
d. STREET ADDRESS 23 Lee St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First John Middle Wesley Last Eades
4. DATE OF DEATH Month Jan Day 31 Year 1957

5. SEX male
6. COLOR OR RACE Cal
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 1-25-1876?
9. AGE (In years last Birthday) 80 Yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Annapolis
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Samuel Eades
14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. —
17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senility — INTERVAL BETWEEN ONSET AND DEATH —
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from —, 19___, to Jan 31, 1957, that I last saw the deceased alive on —, 19___, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE John L. Hedrick M.D.
ADDRESS (Street, city or town, state)
DATE SIGNED 2/1/57
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 2-3-57
22c. NAME OF CEMETERY OR CREMATORY Brewer Hill
22d. LOCATION (City, town, or county) (State) Annapolis, Md

23. FUNERAL DIRECTOR'S SIGNATURE William Reese ADDRESS Annapolis, Md
24a. REC'D BY REGISTRAR DATE
24b. REGISTRAR'S SIGNATURE Wm. J. Francis

FEB 4 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [redacted] hours after death. Page [redacted] may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [redacted] by the funeral director, page [redacted] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00119

141

Reg. Dist. No. 16

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH

COUNTY Anne Arundel — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bristol

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Md COUNTY A. A.

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bristol

STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) James (Middle) Francis (Last) Evans

4. DATE OF DEATH (Month) Jan. (Day) 6 (Year) 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min
M	Colored	Single	July 30, 1955	1 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore	U.S.A.

13. FATHER'S NAME Ernest Evans

14. MOTHER'S MAIDEN NAME Mary Wood

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (A) Bronchopneumonia

ANTECEDENT CAUSE(S) DUE TO (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21e. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 6, 1957, to Jan 6, 1957, that I last saw the deceased alive on [illegible], 19....., and that death occurred at 8:35 AM, from the causes and on the date stated above.

SIGNATURE	ADDRESS (Street, city, town, state)	DATE SIGNED
Emil H. Nelson acting coroner - M.D.	Kirkwood, Md	1-6-57

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	1/10/57	Mosell	Bristol Md

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
JAN 15 1957	Ada Belle Dent	Emil H. Johnson	Annapolis

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

142

CERTIFICATE OF DEATH

00120

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY A. A. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bristol
c. LENGTH OF STAY IN 1b life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bristol
d STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First William Middle McKinley Last EVANS

4. DATE OF DEATH Month Jan Day 24 Year 1957

5. SEX Male
6. COLOR OR RACE Colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Nov. 19
9. AGE (In years last birthday) 55 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Bristol A A.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Thomas Evans
14. MOTHER'S MAIDEN NAME Mary Gray

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Arthur Evans Address Bristol

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 minutes
DUE TO (b) Arteriosclerotic Coronary Disease — Unk
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 24 Jan 1952 to 24 Jan 1957, that I last saw the deceased alive on 24 Jan 1952, and that death occurred at 4:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE W W Lasser M.D. ADDRESS (Street, city or town, state) Upper Marlboro Md DATE SIGNED 1-24-57

[redacted] NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 1/27/57
22c. NAME OF CEMETERY OR CREMATORY Mount
22d. LOCATION (City, town, or county) Drury (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE Annie A. Johnson ADDRESS Annapolis
24a. REC'D BY REGISTRAR DATE JAN 29 1957
24b. REGISTRAR'S SIGNATURE Ida Belle Dent

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page [redacted] should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00121
Reg. Dist. No.

143

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): P.O. Millersville
c. LENGTH OF STAY IN 1b: 14 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Oakdale Circle

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Same — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Same
d. STREET ADDRESS: Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frank — Middle: M. — Last: Fowler

4. DATE OF DEATH: Month: January — Day: 16th — Year: 1957 19

5. SEX: M.

6. COLOR OR RACE: W.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/25/1887

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Operator of a dump
10b. KIND OF BUSINESS OR INDUSTRY: truck

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James H. Fowler

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs. Katherine, Fowler (Wife).

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gustave H. Faubert M.D. — M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 1/16/57

EXAMINER'S NAME (Type): Gustave H. Faubert, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/19/57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS

24a. REC'D BY REGISTRAR — DATE: JAN 21 1957
24b. REGISTRAR'S SIGNATURE: L. M. Joyce

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00122

144 CERTIFICATE OF DEATH

Reg. Dist. No. 24

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The uniform copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M-

1. PLACE OF DEATH
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SEVERN
LENGTH OF STAY (In this place) YEARS
HOSPITAL OR INSTITUTION OR STREET ADDRESS QUEENSTOWN ROAD

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MD COUNTY ANNE ARUNDEL
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X SEVERN
STREET ADDRESS (If rural give location) QUEENSTOWN ROAD

3. NAME OF DECEASED (Type or Print) (First) Samuel (Middle) (Last) Galloway

4. DATE OF DEATH (Month) (Day) (Year) Jan 31- 57 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE Last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	COLORED	WIDOWER	7/6/1846	80 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED	FARMER	ANNE ARUNDEL Co MD	U.S.A.

13. FATHER'S NAME SAMUEL GALLOWAY
14. MOTHER'S MAIDEN NAME GRACE —
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS BERTHA JOHNSON SEVERN MD

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 2 days

ANTECEDENT CAUSE(S) DUE TO (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Cardio Vascular Disease - Senility — 10 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 4-57 19 to Jan 31- 57 19, that I last saw the deceased alive on Jan 30-57 19, and that death occurred at 4:30 A.M., from the causes and on the date stated above.

SIGNATURE AND M.D. Joseph Kyle
ADDRESS (Street, city, town, state) Clarksville Md
DATE SIGNED 1-31-57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	2/3/57	ST REST	HARMONY, MD

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS
February 2 1957	R. W. L. J. Selby	Marshall P. Hayes Baltimore Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

145 Item 12

CERTIFICATE OF DEATH

00123

Reg. Dist. No. 24

1. PLACE OF DEATH
a. COUNTY: A. A. County | MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ferndale
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 21 Ferndale Avenue

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XOFerndale
d. STREET ADDRESS: 21 Ferndale Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Charles	E.	Gill	1	24	1957

5 SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8 DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min
male	white		Aug. 11, 1883	73 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Fireman (Ret'd)	Fire Department	Baltimore	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George E. Gill	Estelle M. Spurry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no		Miss Dorothy Gill, 21 Ferndale Ave., Ferndale

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b) Chronic Hypertension & Senility — 5 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1957 to Jan 1957 that I last saw the deceased alive on Jan 20 1957 and that death occurred at 1 M, from the causes and on the date stated above.

ACTUAL SIGNATURE Charles R. MacDonald M.D. ADDRESS (Street, city or town, state) P.O. Box 296 DATE SIGNED 1-24-57

PHYSICIAN'S NAME (Type) Glen Burnie Md

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	1-28-57	Glen Haven Cemetery	Glen Burnie, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
William Cook, Inc., 1217 St. Paul Street	Jan. 25, 1957	L. J. Dallas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

146

CERTIFICATE OF DEATH

Reg. Dist. No. 00124

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ferndale
c. LENGTH OF STAY IN 1b: 9 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 2 1 Ferndale Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Same — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Same
d. STREET ADDRESS: Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Dorothea Henrietta Middle Gill Last

4. DATE OF DEATH: Month January Day 12th Year 1957

5. SEX: F
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/5/86
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frederick Keller
14. MOTHER'S MAIDEN NAME: Dorothea Edell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Charles E. Gill (Husband) Address: 21 Ferndale Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs.
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) General arteriosclerosis. — ?
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from only today, 19____, to ____, 19____, that I last saw the deceased alive on 1/12/57, 19____, and that death occurred at 4.45 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Gustave H. Faubert M.D. M.D. — ADDRESS (Street, city or town, state): Glen Burnie, Md. — DATE SIGNED: 1/12/57

PHYSICIAN'S NAME (Type): Gustave H. Faubert M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-16-57
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven
22d. LOCATION (City, town, or county) (State): Glen Burnie, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: William Cook, Inc. — ADDRESS: 1217 St. Paul Street
24a. RECD BY REGISTRAR—DATE: JAN 14 1957
24b. REGISTRAR'S SIGNATURE: L. J. Dallas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00108

Reg. Dist. No. 21

109

1. PLACE OF DEATH
a. COUNTY A.A.Co MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Annapolis General Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE MD b. COUNTY A.A.C o
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D #2-Box 243H-
d. STREET ADDRESS Annapolis-MD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Leroy Middle: N. Last: Gosnell
4. DATE OF DEATH Month: 1 Day: 14 Year: 1957
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH August 4, 1900
9. AGE (In years last birthday) 56 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician
10b. KIND OF BUSINESS OR INDUSTRY Local Union
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Clarence W. Gosnell
14. MOTHER'S MAIDEN NAME Estelle Platt
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 215-07-5338
17. INFORMANT Address: Mrs. Vera K. Geldmacher 3533 W. Caton Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Disease — INTERVAL BETWEEN ONSET AND DEATH Sudden
4.3
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE E. Linhardt M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) E. Linhardt-Annapolis-MD
DATE SIGNED 1-15-57

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 1/18/57
22c. NAME OF CEMETERY OR CREMATORY Mt. Olive
22d. LOCATION (City, town, or county) (State) Randalstown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS James F. Burnside, Jr. 1900 Eutaw Place
24a. REC'D BY REGISTRAR DATE JAN 17 19
24b. REGISTRAR'S SIGNATURE Wm. J. French

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

110

CERTIFICATE OF DEATH

00125

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 16 Monument Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EDWARD Middle — Last GREEN

4. DATE OF DEATH: Month JAN Day 24 Year 1957

5. SEX: M
6. COLOR OR RACE: Col
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3-19-1879
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Annapolis Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Green
14. MOTHER'S MAIDEN NAME: Bessie Robinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 214-05-068
17. INFORMANT: Anna Salonia Turner — Address: Annapolis Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hemorrhage due rupture of
DUE TO (b): Ruptured Varicosities
DUE TO (c): Carcinoma of the liver
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 15, 1956 to Jan 24, 1957, that I last saw the deceased alive on Jan 22, 1957, and that death occurred at 1:30 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE: R. L. Richardson M.D.
ADDRESS (Street, city or town, state): 110 Duke of Gloucester St. Annapolis Md.
DATE SIGNED: 1/26/57
PHYSICIAN'S NAME (Type): R. L. RICHARDSON (MD)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-27-57
22c. NAME OF CEMETERY OR CREMATORY: Brewer Stull
22d. LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese II
ADDRESS: Annapolis Md.
24a. REC'D BY REGISTRAR DATE: 1-29-57
24b. REGISTRAR'S SIGNATURE: Wm. J. Francis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00126

CERTIFICATE OF DEATH

147

Reg. Dist. No. 28

1. PLACE OF DEATH

COUNTY: Anne Aruundel [redacted]

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Crownsville

LENGTH OF STAY (in this place): 5 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland COUNTY: Wicomico

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tyaskin

STREET ADDRESS (If rural give location): R.F.D.

3. [redacted] OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
Mary	Ann	Green	Jan. 16 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Negro	Widowed	Not given	79? yrs.	—	—		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Maryland	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Not given	Not given

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S ADDRESS
No	---- --	---------	Crownsville Hospital Hospital Records Crownsville, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Uremia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSE(S) DUE TO (B) Pyelonephritis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Dehydration - Arteriosclerosis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/12 ., 1957, to 1/16, 1957, that I last saw the deceased alive on 1/16, 1957, and that death occurred at 6:30 P.M., from the causes and on the date stated above.

SIGNATURE Lisell M. Kreuz Jopp. M.D. ADDRESS (Street, city, town, state) Crownsville, Md. DATE SIGNED 1/17/57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1/26/57	White Haven Cem.	White Haven Md.

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
DATE FEB 4 1957	L. M. Joyce	C. L. Messick, Bivalve, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00127

111

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 221 S. Cherry Grove Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Davidsonville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: ETTA — Middle: GLOVER — Last: GRASS

4. DATE OF DEATH: Month: JANUARY — Day: 24 — Year: 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 7, 1884
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jausha Glover
14. MOTHER'S MAIDEN NAME: Mary Crandell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): --
(If yes, give war or dates of service): - - - - - -
16. SOCIAL SECURITY NO.: - - - - - -
17. INFORMANT: Mr. Oscar Fay Grimes- Husband- same as # 2 — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 4 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cardio-Vascular Renal Ulcers — 4yrs.
DUE TO (c): Arteriosclerosis Senelis — 4yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 10, 1949 to Jan 24, 1957 that I last saw the deceased alive on Jan. 24, 1957, and that death occurred at 1:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James S. Martin M.D.
ADDRESS (Street, city or town, state): 6 Shaw Street, Annapolis, Maryland
DATE SIGNED: 1/25/57
PHYSICIAN'S NAME (Type): James S. Martin MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: January 26, 57
22c. NAME OF CEMETERY OR CREMATORY: Davidsonville Methodist
22d. LOCATION (City, town, or county) (State): Davidsonville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: HOPPING FUNERAL HOME
ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: 1/25/57
24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 4

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

148

CERTIFICATE OF DEATH

00128 21
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY A. A. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Best Gate
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE Md. b. COUNTY A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Best Gate,
d. STREET ADDRESS R. 1 Annapolis
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Mercedith Middle Alice Last Harrod
4. DATE OF DEATH Month January Day 18, Year 1957

5. SEX Fem.
6. COLOR OR RACE Colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Nov. 1 1888
9. AGE (In years last birthday) 68 yrs.
IF UNDER 1 YEAR Months 2 Days 26
IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Charleston W.A.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William C. Harrod
14 MOTHER'S MAIDEN NAME Harrod Ann Shaw

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 7.11K
17 INFORMANT Address Isabella Harrod R. 1 Annapolis

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-14-56 19____, to 1-18-57 19____, that I last saw the deceased alive on 1-17-57 19____, and that death occurred at 10:25 M, from the causes and on the date stated above.

ACTUAL SIGNATURE C. T. Cole M.D. ADDRESS (Street, city or town, state) C 2 Cathedral St DATE SIGNED

PHYSICIAN'S NAME (Type) A. T. ALLEN Annapolis Md

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF
22c. NAME OF CEMETERY OR CREMATORY
22d. LOCATION (City, town, or county) (State)

23 FUNERAL DIRECTOR'S SIGNATURE Emil A. Hinson ADDRESS Annapolis
24a REC'D BY REGISTRAR DATE 1-23-1957
24b. REGISTRAR'S SIGNATURE Wm. J. Francis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

149

CERTIFICATE OF DEATH

00129

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: A.A. ~~Harford~~ Co — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE: Maryland b. COUNTY: A. A. Co.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dorsey

c. LENGTH OF STAY IN 1b: Approx. 50 yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dorsey (~~Elkridge~~ 09 ~~P.O.~~) Hanover R.D.

d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION)

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Philip Middle: Peter Last: Heil

4. DATE OF DEATH: Month: January Day: 6th Year: 1957

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb. 12, 1887

9. AGE (In years last birthday): 69 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Brakeman (Ret'd)

10b. KIND OF BUSINESS OR INDUSTRY: B. & O. Railroad

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Phillip Heil

14. MOTHER'S MAIDEN NAME: Mary A. ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address: John L. Heil, 3218 Acton Road, Baltimore 14

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Haemorrhage

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hemiplegia

DUE TO (c):

33 ix

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/4/57, 19____, to 1/6/57, 19____, that I last saw the deceased alive on 1/6/57, 19____, and that death occurred at 11:50 P M. From the causes and on the date stated above.

ACTUAL SIGNATURE: Frank E. Shipley, M.D.

ADDRESS (Street, city or town, state): Savage, Md.

DATE SIGNED: 1/7/57

PHYSICIAN'S NAME (Type): Frank E. Shipley

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1-9-57

22c. NAME OF CEMETERY OR CREMATORY: St. Lawrence Cemetery

22d. LOCATION (City, town, or county) (State): Jessups, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: William Cook, Inc. 1217 St. Paul Street

24a. REC'D BY REGISTRAR DATE: JAN 9 1957

24b. REGISTRAR'S SIGNATURE: Clara Hasley

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 1SM 9/55

Page 4

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

150

CERTIFICATE OF DEATH

00130

Reg. Dist. No. 14

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
d. STREET ADDRESS: Rockview Beach
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Daniel; Middle: Kent; Last: Ireland

4. DATE OF DEATH: Month: January; Day: 7; Year: 1957

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: January 25, 1865

9. AGE (In years last birthday) 91 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Conductor

10b. KIND OF BUSINESS OR INDUSTRY: Balto. Transit Co

11. BIRTHPLACE (State or foreign country): Calvert County, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John F. Ireland

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
If yes, give war or dates of service:

16. SOCIAL SECURITY NO.

17. INFORMANT: John F. Ireland, Address: Rockview Beach, Pasadena, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: ½ hour
DUE TO
(b): Arteriosclerotic Cardio-vascular disease — Several years
DUE TO
(c):

I22.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from December 1, 1956 to January 7, 1957 that I last saw the deceased alive on January 7, 1957, and that death occurred at 5:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. M. McLaughlin M.D. ADDRESS (Street, city or town, state): Pasadena, Md. DATE SIGNED: Jan. 7, 1957

PHYSICIAN'S NAME (Type): R.M. McLaughlin

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-10-57
22c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery
22d. LOCATION (City, town, or county) (State): Baltimore

23. FUNERAL DIRECTOR'S SIGNATURE: William Cook, Inc., ADDRESS: 1217 St. Paul Street

24a. REC'D BY REGISTRAR DATE: JAN 9 1957
24b. REGISTRAR'S SIGNATURE: L. J. Dallas

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 Film 6209 1-25-57 et

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CERTIFICATE OF DEATH

Reg. Dist. No. 001318

1. PLACE OF DEATH
a. COUNTY: Ann Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore Crownsville
c. LENGTH OF STAY IN 1b: 1 year
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 2013 Llewlyn Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Mary — Middle Ruth — Last Jenkins

4. DATE OF DEATH: Month January — Day 13 — Year 19 57

5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 11, 1901??
9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): No record
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: No record
14. MOTHER'S MAIDEN NAME: Ruth Jenkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: No record
17. INFORMANT: Hospital Record — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Edema
DUE TO
(b): Bronchopneumonia
DUE TO
(c): Congestive Heart Failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 434.1

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 22, 19 56, to January 13, 19 57, that I last saw the deceased alive on January 13, 19 57, and that death occurred at 2 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: John J. McGee M.D. ADDRESS (Street, city or town, state): Crownsville State Hosp DATE SIGNED: January 13, 1957

PHYSICIAN'S NAME (Type): John J. McGee, M.D. Crownsville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: JAN 17/57
22c. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem.
22d. LOCATION (City, town, or county) (State): A. A. County Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Milton E. Eichorn Sr. ADDRESS: 1129 N. Carlton St
24a. REC'D BY REGISTRAR DATE: 1/17/57
24b. REGISTRAR'S SIGNATURE: L. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

152

CERTIFICATE OF DEATH

00132

Reg. Dist. No. 24

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 5 mo
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 132 Carroll Rd

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Balto-City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brookview Apartments
d. STREET ADDRESS: Charles St. Balto-18
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BLANCHE — Middle L — Last JOHNSON

4. DATE OF DEATH: Month JAN — Day 4 — Year 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 27, 1880

9. AGE (In years last birthday): 76 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework (ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles B. Lowe

14. MOTHER'S MAIDEN NAME: Mary A. Lisle — 132 Carroll Rd. Glen Burnie, Md

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs Anna Lisle — Address: Same as #1

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute pulmonary congestion — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Cerebral vascular accident — 3 days

DUE TO

(c) arteriosclerosis — 10 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): bilat. cataracts, aortic regurgitation

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): no

20c. TIME OF INJURY Hour o. p. m. p. m — Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): no

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4 December, 1956, to 4 Jan, 1957, that I last saw the deceased alive on 4 Jan, 1957, and that death occurred at 3:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Hubert F. Manuzak M.D. — ADDRESS (Street, city or town, state): 901 Edgerly Rd, Glen Burnie, Md — DATE SIGNED: 4 Jan 57

PHYSICIAN'S NAME (Type): HUBERT F. MANUZAK — GLEN BURNIE, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Jan 7, 1957 — 22c. NAME OF CEMETERY OR CREMATORY: Meadowridge Mem. Pk. — 22d. LOCATION (City, town, or county) (State): Howard Co. Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: T. E. Singleton — ADDRESS:

24a REC'D BY REGISTRAR DATE: Jan 7, 1957 — 24b REGISTRAR'S SIGNATURE: L. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00133

153

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 14 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown Boonsboro
d. STREET ADDRESS: Lakin Avenue — County Home / Lot / Area
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Jennie — Middle: — Last: Johnson

4. DATE OF DEATH: Month: 1 — Day: 3 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐: Unknown

8. DATE OF BIRTH: Not listed

9. AGE (In years last birthday): 81? yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unk.

10b. KIND OF BUSINESS OR INDUSTRY: Unk.

11. BIRTHPLACE (State or foreign country): Unk.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Unk.

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service): Unk.

16. SOCIAL SECURITY NO: Unk.

17. INFORMANT: Hospital Records — Address: Crownsville State Hospital, Crownsville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH

442 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertensive Cardiovascular - Renal Disease

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypostatic Penumonia and Senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12/20, 19 56, to 1/3, 19 57, that I last saw the deceased alive on 1/3, 19 57, and that death occurred at 7:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp. M.D.

ADDRESS (Street, city or town, state): Crownsville, Md.

DATE SIGNED: 1/4/57

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: JANUARY-12-1957

22c. NAME OF CEMETERY OR CREMATORY: BOONSBORO CEMETERY

22d. LOCATION (City, town, or county) (State): BOONSBORO WASH. CO. MD.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: Boonsboro Md.

24a. REC'D BY REGISTRAR DATE: JAN 14 1957

24b. REGISTRAR'S SIGNATURE: L. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

: 154

CERTIFICATE OF DEATH

00134

Reg. Dist. No. 28

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page ■ may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages ■ and ■ should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 1 yr. 3 mos. 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City
d. STREET ADDRESS: 556 W. Lanvale Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Rebecca — Middle: Owens — Last: Johnson

4. DATE OF DEATH: Month: 1 — Day: 8 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12/5/79

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months —
IF UNDER 24 HRS: Days —, Hours —, Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Housework

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: [illegible] Squire Johnson

14. MOTHER'S MAIDEN NAME: [illegible] Margaret Foster

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk.
(If yes, give war or dates of service): Unk.

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT: Hospital Records
Address: Crownsville State Hospital, Crownsville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypostatic Penumonia
4 d d. 1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Senility
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic cardiovascular Disease

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/14, 1956, to 1/8, 1957, that I last saw the deceased alive on 1/8, 1957, and that death occurred at 9:30a. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D.
ADDRESS (Street, city or town, state): Crownsville, Md.
DATE SIGNED: 1/9/57

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/12/57
22c. NAME OF CEMETERY OR CREMATORY: Magothy Cemetery
22d. LOCATION (City, town, or county) (State): Magothy A.A. Md

23. FUNERAL DIRECTOR'S SIGNATURE: Mrs Retta R. Williams
ADDRESS: 372 N. Edmondson Ave

24a. REC'D BY REGISTRAR: DATE JAN 11 1957
24b. REGISTRAR'S SIGNATURE: H. M. Joyce

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

00135

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis,
d. STREET ADDRESS: 909 Wells Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First (Mike) Middle GEORGE Last S. JONES

4. DATE OF DEATH: Month JANUARY Day 30 Year 19 57

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 3, 1889
9. AGE (In years last birthday): 68 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Labor Forman
10b. KIND OF BUSINESS OR INDUSTRY: U.S.GOV.
11. BIRTHPLACE (State or foreign country): Annapolis, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Jones
14. MOTHER'S MAIDEN NAME: Mary Holland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT Address: Mrs. Stella Marie Jones- Wife- same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 56, to Jan. 30, 1957 that I last saw the deceased alive on Jan 28, 1957, and that death occurred at 4:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John L. Hedeman M.D.
ADDRESS (Street, city or town, state): 90 Catherdral Street, Annapolis, Md.
DATE SIGNED: 2/1/57

PHYSICIAN'S NAME (Type): John Hedeman MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-2-57
22c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery
22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] HIPPING FUNERAL HOME
ADDRESS: Annapolis, Maryland
24a. REC'D BY REGISTRAR DATE: FEB 4 1957
24b. REGISTRAR'S SIGNATURE: Wm. J. Frenchy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

113

CERTIFICATE OF DEATH

00136 21

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A. A. General Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: A. A. Co
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mayo
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Laverne — Middle: Marie — Last: Jones

4. DATE OF DEATH: Month: 1 — Day: 10 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: Col.

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-11-56

9. AGE (In years last birthday): yrs.

IF UNDER 1 YEAR: Months: 6 — Days: — IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Amos Jones Jr.

14. MOTHER'S MAIDEN NAME: Mable Stewart

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: —

17. INFORMANT: Amos Jones — Address: Mayo, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 11 days

DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State):

21. I certify that I attended the deceased from 1-2-57, 19—, to 1-10-57, 19—, that I last saw the deceased alive on 1-10-57, 19—, and that death occurred at 6:25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A T Alley M.D. — ADDRESS (Street, city or town, state): 69 Cathedral St Annapolis and — DATE SIGNED: 1-11-57

PHYSICIAN'S NAME (Type): A. T. ALLEY

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 1-12-57 — 22c. NAME OF CEMETERY OR CREMATORY: at Mayo — 22d. LOCATION (City, town, or county) (State): Mayo Md

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese II — ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR — DATE: JAN 12 '57 — 24b. REGISTRAR'S SIGNATURE: Wm. J. Francke

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00137

155 CERTIFICATE OF DEATH

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne-Arundel; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Harmons; LENGTH OF STAY (in this place) Life; HOSPITAL OR INSTITUTION OR STREET ADDRESS Dorsey Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne-Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Harmons; STREET ADDRESS (If rural, give location) Dorsey Road

3. NAME OF DECEASED (Type or Print): (First) J (Middle) (Last) HARPER KELBAUGH

4. DATE OF DEATH: (Month) Jan. (Day) 27 (Year) 1957

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: Dec. 20-1911

9. AGE last birthday: 45 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Developer

10b. KIND OF BUSINESS OR INDUSTRY: Self-Employed

11. BIRTHPLACE (State or foreign country): Anne Arundel Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Emory Kelbaugh

14. MOTHER'S MAIDEN NAME: Olga Black

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If year, give war or dates of service) —

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT AND ADDRESS: Mrs. Elizabeth Farthing — 114 Dinsmore Ave. Ferndale Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) MYOCARDIAL INFARCTION

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) HYPERTENSION

(c) GENERALIZED ARTERIOSCLEROSIS

Interval Between Onset and Death: (a) N.O

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 27 Dec, 1956, to 2 JAN, 1957, that I last saw the deceased alive on 20 JAN, 1957, and that death occurred at 8:00 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

George E Groleau MD Elkridge 27 md 28 JAN. 57

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: Jan. 30-1957

NAME OF CEMETERY OR CREMATORY: Friendship Cemetery

LOCATION (City, town, or county) (State): Ft. Meade Rd. A.Co. Md.

DATE REC'D BY LOCAL REG.: Jan 29 1957

REGISTRAR'S SIGNATURE: L J D'Alba

24. FUNERAL DIRECTOR: R. V. Singleton

ADDRESS: Glen Burnie Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00138

156

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~[illegible]~~ Crownsville
c. LENGTH OF STAY IN 1b: 40 hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City
d STREET ADDRESS: 1007 Brantley Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Ida — Middle — Last Keys
4. DATE OF DEATH: Month Jan — Day 26 — Year 1957

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: unknown
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Day worker
10b. KIND OF BUSINESS OR INDUSTRY: Domestic
11 BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Mrs Rena J. Brown — Address: 1007 Bently Street, Balt.,Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary insuficiency — INTERVAL BETWEEN ONSET AND DEATH

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Arteriosclerotic Hypertensive Cardiovascular disease

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebral Vascular accident.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 24, 19 57, to Jan 26, 19 57, that I last saw the deceased alive on Jan 25, 1957, and that death occurred at 2.05 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Conwell Newton M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital — DATE SIGNED: 1-26-57

PHYSICIAN'S NAME (Type): Conwell Newton — Crownsville, Marlkand

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-29-57
22c. NAME OF CEMETERY OR CREMATORY: Brooks, Inc'l
22d. LOCATION (City, town, or county) (State): Calvert County, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Charles A. Rice — ADDRESS: 6610 Barrett
24a. REC'D BY REGISTRAR DATE: 1-30-57
24b. REGISTRAR'S SIGNATURE: L. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

157

CERTIFICATE OF DEATH

Reg. Dist. No. 00139

Item 16 Film 211 3-8-57 ams

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G. Meade
c. LENGTH OF STAY IN 1b: 2 hrs 16 min
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Army Hospital

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Massachusetts
b. COUNTY: Barnstable
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): West Barnstable 58 x -
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EDNA Middle ELIZABETH Last LACOURCIERE

4. DATE OF DEATH: Month January Day 28 Year 19 57

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10 March 1918
9. AGE (In years last birthday): 38 yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): England
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Smith
14. MOTHER'S MAIDEN NAME: Mary Clewes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO: Unknown
17. INFORMANT: Husband, 1662 Waverly Way, Baltimore 12, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (1) Inevitable abortion (2) acute endometritis

DUE TO (b) (3) generalized capillary congestion (history of cardiac arrhythmia with profound shock)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) (4) acute pulmonary congestion and (5) edema.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 28, 19 57, to Jan 28, 19 57, that I last saw the deceased alive on Jan 28, 19 57, and that death occurred at 1316 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Murray K Mantooth M.D. ADDRESS (Street, city or town, state): USAH, Fort George G. Meade, Md. DATE SIGNED: 28 Jan 57

PHYSICIAN'S NAME (Type): MURRAY K. MANTOOTH, CAPT, MC, USAH, Fort George G. Meade, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/2/57
22c. NAME OF CEMETERY OR CREMATORY
22d. LOCATION (City, town, or county) (State): Hyannis, Mass

23. FUNERAL DIRECTOR'S SIGNATURE: William Cook ADDRESS: St Paul & Preston St Baltimore MD

24a. REC'D BY REGISTRAR DATE: 28 Jan 57
24b. REGISTRAR'S SIGNATURE: W. L. SAYLOR, 1ST LT, MSC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 2 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00140

158 Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Edgewater, Maryland

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
d. STREET ADDRESS: Edgewater, Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MABEL Middle L Last LARRIMORE

4. DATE OF DEATH: Month JANUARY Day 14, Year 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 4, 1885

9. AGE (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: own Home

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert Smith

14. MOTHER'S MAIDEN NAME: Katey (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO: none

17. INFORMANT Address: William D. Larrimore- Husband- same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hypertension — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour 6:30 ☒ a.m. ☐ p.m. Month, Day, Year 1-14- 19 57

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Edgewater, Anne Arundel, Md.

21. I certify that I take charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒; and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: January 15, 1957

EXAMINER'S NAME (Type): Elmer G. Linhardt

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Jan. 17, 57

22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial Cemet.

22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: [signature] ADDRESS: Hopping Funeral Home Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: JAN 16 1957

24b. REGISTRAR'S SIGNATURE: Wm. J. French

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

00141

Reg. Dist. No. 24

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gibson Island
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Paisley Rd. Gibson Island

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gibson Island
d STREET ADDRESS: Paisley Rd, Gibson Island
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Margaret — Middle Bell — Last Lee

4. DATE OF DEATH: Month January — Day 4 — Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 16, 1883
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel Marshall Mac.Donald
14. MOTHER'S MAIDEN NAME: Elizabeth Ann Croom

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Daughter - M. Elizabeth Lee — Address: Gibson Island, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

DUE TO (b): Pulmonary edema — 1½ hrs.

DUE TO (c): Arteriosclerotic cardiovascular disease — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 4, 1957, to January 4, 1957, that I last saw the deceased alive on January 4, 1957, and that death occurred at 8:55 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Kathleen H. Lyons M.D. — ADDRESS (Street, city or town, state): Paisley Rd, Gibson Island Md. — DATE SIGNED: 1/4/57

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 1/6/57
22c. NAME OF CEMETERY OR CREMATORY: Cross Creek Cem.
22d. LOCATION (City, town, or county) (State): Fayetteville, N. C.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm J. Lichtner & Sons — ADDRESS: Balto 17, Md
24a. REC'D BY REGISTRAR DATE: 1/6/57
24b. REGISTRAR'S SIGNATURE: L. J. Dealley

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

114

CERTIFICATE OF DEATH

Reg. Dist. No. 00142

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Ann Arundel General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Shady Side
d. STREET ADDRESS: Leeds Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Albert — Last: Leek

4. DATE OF DEATH: Month: January — Day: 21 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 15 October 1901

9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Artist

10b. KIND OF BUSINESS OR INDUSTRY: Publishing

11. BIRTHPLACE (State or foreign country): Knoxville, Tennessee U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Cal C Leek

14. MOTHER'S MAIDEN NAME: Minnie V. Weighbert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Alma Neff Leek — Address: Wife.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion acute — INTERVAL BETWEEN ONSET AND DEATH: One hour.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Ventricular fibrillation (Clinical) — one hour.
DUE TO (c): Old myocardial infarction.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized Arteriosclerosis.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 55, 19__, to January, 19 57, that I last saw the deceased alive on 21 January, 19 57, and that death occurred at 1:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Franklin D Hendricks M.D. — ADDRESS (Street, city or town, state): Shady Side — DATE SIGNED

PHYSICIAN'S NAME (Type): Franklin D Hendricks

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1-24-57

22c. NAME OF CEMETERY OR CREMATORY: Forest Lincoln

22d. LOCATION (City, town, or county) (State): Bladensburg Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. W. Lee Sons — ADDRESS: Wash. D. C.

24a. REC'D BY REGISTRAR — DATE:

24b. REGISTRAR'S SIGNATURE: Wm. J. Fenchin

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 1 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

00143

115 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural; LENGTH OF STAY (In this place) 12 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hospital Annapolis, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural; Annapolis, Md.; STREET ADDRESS (If rural, give location) Defence Highway Glenbrook aa co md

3. NAME OF DECEASED (Type or Print): (First) Louis (Middle) (Last) LEGG

4. DATE OF DEATH: (Month) 1 (Day) 3 (Year) 1957

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: ??

9. AGE last birthday: 70 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bartender

10b. KIND OF BUSINESS OR INDUSTRY: Tavern

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: ??

14. MOTHER'S MAIDEN NAME: ??

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 234-16-2123

17. INFORMANT AND ADDRESS: Goldie Wiseman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Arteriosclerosis Secondary

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic Myocarditis

(c) Dead on arrival at hospital in ambulance

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE [signature] (Degree or title) MD ADDRESS [signature] DATE SIGNED 1/6/57

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE THEREOF Jan 5-57; NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery; LOCATION (City, town, or county) Woodly aa co (State) md

DATE REC'D BY LOCAL REG. Jan 7, 1957; REGISTRAR'S SIGNATURE L. J. Draeb.

24. FUNERAL DIRECTOR Leonard A Fink; ADDRESS Glen Burnie Md

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

116

CERTIFICATE OF DEATH

00144

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: MD
b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: SPA Rd & Hill Top. Ln.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Alice Middle Linthicum Last
4. DATE OF DEATH: Month Jan. Day 22 Year 1957

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan 23, 1874
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Keeper.
10b. KIND OF BUSINESS OR INDUSTRY: Home.
11. BIRTHPLACE (State or foreign country): Annapolis
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Theodore Hodgkin Linthicum
14. MOTHER'S MAIDEN NAME: Georgeanna Mitchell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No.
16. SOCIAL SECURITY NO.:
17. INFORMANT: ~~Mother~~ SISTER Mrs. Marie Linthicum Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH
460.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Generalized arteriosclerosis
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1957, 19____, to Jan. ____, 1957, that I last saw the deceased alive on 1-22-57, 19____, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert R Hahn M.D. ADDRESS (Street, city or town, state): Severna Park md DATE SIGNED: 1-22-57

PHYSICIAN'S NAME (Type): Robert R. Hahn. Severna Park MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-23-57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff
22d. LOCATION (City, town, or county) (State): Annapolis Md

23. FUNERAL DIRECTOR'S SIGNATURE: John F. Taylor Sons ADDRESS: Annapolis Md
24a. REC'D BY REGISTRAR DATE: 1/21/57
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

117

CERTIFICATE OF DEATH

Reg. Dist. No. 00145

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1243 Tyler Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 1243 Tyler Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Raymond Middle George Last Lorenzen
4. DATE OF DEATH: Month January Day 3 Year 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 7, 1909
9. AGE (In years last birthday): 47 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineman
10b. KIND OF BUSINESS OR INDUSTRY: Diesel Motors
11. BIRTHPLACE (State or foreign country): North Dakota
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James T. Lorenzen
14. MOTHER'S MAIDEN NAME: Margaret McCory

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 1930-34
16. SOCIAL SECURITY NO.:
17. INFORMANT: Doris V. Lorenzen — Address (2)

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 18, 1946 to Jan. 3, 1957, that I last saw the deceased alive on Dec. 28, 1956, and that death occurred at 8:35 AM, from the causes and on the date stated above.
ACTUAL SIGNATURE: Maurice F. Klawans M.D.
ADDRESS (Street, city or town, state): 31 Southgate Ave., Annapolis, Md.
DATE SIGNED: 1/4/57
PHYSICIAN'S NAME (Type): MAURICE F. KLAWANS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan. 5, 1957
22c. NAME OF CEMETERY OR CREMATORY: St. Mary's
22d. LOCATION (City, town, or county) (State): Annapolis Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Sons
ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: 1/4
24b. REGISTRAR'S SIGNATURE: U. Unrue

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

00146

118 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. .....

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) R.F.D. 1 Route 2 Riva Rd

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Howard	Stanley	Sovrag	Jan	21	57 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	married	June 4 1893	63 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Moving	Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Chas A Sovrag	Livie Wright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
		Catherine Sovrag Riva Rd Annapolis Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
4 d 0 1 Immediate cause	(a) Acute Coronary Thrombosis	12 hours
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary artery disease	3 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

WAS AT CAUSE, WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
m.		

22 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

DISPOSITION (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan 25 57	Ballmore	Balto

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1/24/57	C. N. Hedrick	Wells Funeral Home	4210 Belair Rd

MARGIN RESERVED FOR BINDING

A. WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

160 [illegible] Reg. Dist. No. 00147

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sibley in Bay
c. LENGTH OF STAY IN 1b 3 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) [illegible]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY D. C
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mark D. C
d. STREET ADDRESS 5329 [illegible]
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Edward Middle Joseph Last Lynch

4. DATE OF DEATH: Month 1 Day 22 Year 1957

5. SEX M

6. COLOR OR RACE W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 2-2-1895

9. AGE (In years last birthday) 62 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY Bricklayer

11. BIRTHPLACE (State or foreign country) D. C

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME Michael P Lynch

14. MOTHER'S MAIDEN NAME Mary E Lyc Rooney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) [illegible]
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Coronary Insuff
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH: (a) [illegible] (b) Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE [signature] M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 1/22/57

EXAMINER'S NAME (Type) E. Linhardt

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 1-26-57
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.
22d. LOCATION (City, town, or county) (State) Washington D C

23. FUNERAL DIRECTOR'S SIGNATURE [signature] ADDRESS [illegible] Wash. D C
24a. REC'D BY REGISTRAR DATE 1/23/57
24b. REGISTRAR'S SIGNATURE [signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain on certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

161

CERTIFICATE OF DEATH

00148

Reg. Dist. No. 24

1 PLACE OF DEATH
a. COUNTY Anne Arundel — MARYLAND

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE Md. b. COUNTY AA

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena

c. LENGTH OF STAY IN 1b 15 yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pasadena Rd. Rte.9, Box 52

d STREET ADDRESS Pasadena Rd., Rte9, Box 52

e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Lost: William James Majerowicz(Myers)

4. DATE OF DEATH Month Jan. Day 3 Year 1957

5 SEX Male

6. COLOR OR RACE White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Feb. 8, 1896

9. AGE (In years last birthday) 60 yrs

IF UNDER 1 YEAR Months Days

IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician

10b. KIND OF BUSINESS OR INDUSTRY Md. Drydock

11. BIRTHPLACE (State or foreign country) Baltimore , Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Valentine Majerowicz

14. MOTHER'S MAIDEN NAME Josephine Radowski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I

16. SOCIAL SECURITY NO. 215-09-7220

17. INFORMANT Address: Mrs Lillian Majerowski, Same as 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH about 18 mo

162 X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 16, 1953, to January 3, 1957, that I last saw the deceased alive on December 26, 1956, and that death occurred at 10 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE Bobby L. Jennings M.D. ADDRESS (Street, city or town, state) 104 Crain Hwy S DATE SIGNED 1/4/57

PHYSICIAN'S NAME (Type) BOBBY L. JENNINGS MD Glen Burnie Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF Jan. 7, 1957

22c. NAME OF CEMETERY OR CREMATORY St. Marys

22d. LOCATION (City, town, or county) Annapolis, (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley ADDRESS Hopping and Kirkley, Glen Burnie, Md.

24a. REC'D BY REGISTRAR DATE JAN 7 1957

24b REGISTRAR'S SIGNATURE L. J. Dealbay

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00149

162 **CERTIFICATE OF DEATH**

Reg. Dist. No. 16

1. PLACE OF DEATH

COUNTY Anne Arundel — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shady Side

LENGTH OF STAY (In this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Anne Arundel

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shady Side

STREET ADDRESS (If rural give location) —

3. NAME OF DECEASED (Type or Print) (First) Christina (Middle) Lorene (Last) Marksberry

Christina Lorene (Race) Marksberry

4. DATE OF DEATH (Month) Jan. (Day) 4, (Year) 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widow	Jan. 23, 1878	78 yrs.	11			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Dry Ridge Kentucky

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Race-

14. MOTHER'S MAIDEN NAME Sarah Benson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT & ADDRESS Mrs H·E·Stallings · Dau ·

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Carcinoma pancreas-

ANTECEDENT CAUSE(S) DUE TO (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) multiple metastases

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) — 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. — 21e. INJURY OCCURRED While at work ☐ Not while at work ☐ — 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 4, 19 57, to Jan 4, 19 57, that I last saw the deceased alive on Jan 4, 19 57, and that death occurred at 3:35 P.M, from the causes and on the date stated above.

SIGNATURE Emily H. Wilson M.D. **ADDRESS** (Street, city, town, state) Lothian, Md **DATE SIGNED** 1-4-57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1/8/57		Williamstown, Kentucky

24. REC'D BY REGISTRAR DATE JAN 1957 — REGISTRAR'S SIGNATURE Ida Belle Dent

25. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hyson Co. — ADDRESS Wash. D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

163

CERTIFICATE OF DEATH

00150

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 302 Glenwood Ave
c. LENGTH OF STAY IN 1b: 3 mos
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Glen Burnie, Maryland

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia — b. COUNTY: Southampton
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Boykins
d. STREET ADDRESS: R. F. D.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DAVID — Middle HILTON — Last MARTIN

4. DATE OF DEATH: Month January — Day 25 — Year 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11 Nov. 1873

9. AGE (In years last birthday): 83 yrs.
If UNDER 1 YEAR: Months — Days
If UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mill worker

10b. KIND OF BUSINESS OR INDUSTRY: Lumber Co.

11. BIRTHPLACE (State or foreign country): Hamilton, N. Carolina

12. CITIZEN OF WHAT COUNTRY? Yes - USA

13. FATHER'S NAME: Deceased (unknown)

14. MOTHER'S MAIDEN NAME: Deceased (unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Son - Jos. W. Martin — Address: 302 Glenwood Ave, Glen Burnie, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intra-abdominal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Duodenal ulcer — 5 yrs
DUE TO
(c): Hypertension — 10 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic Heart Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 24, 1957, to Jan. 25, 1957, that I last saw the deceased alive on Jan 24, 1957, and that death occurred at 8:35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Hubert F. Mahuzak, M.D.
ADDRESS (Street, city or town, state): 901 Edgerly Rd Glen Burnie, Md
DATE SIGNED: Jan 26, 1957

PHYSICIAN'S NAME (Type): HUBERT F. MAHUZAK

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan 28, 1957
22c. NAME OF CEMETERY OR CREMATORY: Scotland Neck Cem
22d. LOCATION (City, town, or county) (State): Scotland Neck, N. Carolina

23. FUNERAL DIRECTOR'S SIGNATURE: R. L. Singleton
ADDRESS: Glen Burnie, Maryland

24a. REC'D BY REGISTRAR DATE: Jan 29, 1957
24b. REGISTRAR'S SIGNATURE: L. x D. Carter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

164

CERTIFICATE OF DEATH

00151

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A.A
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RIVA
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: RIVERVIEW NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MD
b. COUNTY: A.A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RIVA, MD
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle A. Last MARTIN

4. DATE OF DEATH: Month 1 Day 5 Year 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Unknown about 70 yrs

9. AGE (In years last birthday)

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INSURANCE

10b. KIND OF BUSINESS OR INDUSTRY: SALESMAN

11. BIRTHPLACE (State or foreign country): NEW YORK

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM S. MARTIN

14. MOTHER'S MAIDEN NAME: SARAH LONG

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: EDITH N. MARTIN Address #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): arteriosclerotic cardio vascular — INTERVAL BETWEEN ONSET AND DEATH:
422.1
DUE TO
(b): disease — 10yr
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): senile dementia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Jan, 1940, to Jan. 5, 1956, that I last saw the deceased alive on Jan 5, 1957, and that death occurred at 8:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: S Bonsnick M.D.
ADDRESS (Street, city or town, state): Annapolis Md
DATE SIGNED: 1/6/57

PHYSICIAN'S NAME (Type): S Bonsnick

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 1-6-57
22c. NAME OF CEMETERY OR CREMATORY: CEDAR BLUFF
22d. LOCATION (City, town, or county) (State): ANNAPOLIS MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Tyler & Sons
ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: 1/7
24b. REGISTRAR'S SIGNATURE: U. Brinck

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completed as filled in by the funeral director, the third copy death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00152

119

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH

COUNTY: Anne Arundel — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis Md

LENGTH OF STAY (In this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Homewood Rest Home

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland — COUNTY: Prince Georges

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale, Md. 16-25

STREET ADDRESS (If rural give location): 5411 Quintana st.

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Emma (Last) Mayhew

4. DATE OF DEATH (Month) (Day) (Year): Jan 23, 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widowed	July 1, 1883	73 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Virginia	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Arthur A Murphy	Annie Mitch[illegible]

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
no		none	[illegible] Riverdale, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 2 mos

ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B): Arteriosclerosis generalized — unknown

DUE TO (C):

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/14, 19 57, to 1/23, 19 57, that I last saw the deceased alive on 1/22, 19 57, and that death occurred at 3:00 A.M. from the causes and on the date stated above.

SIGNATURE Edward L Beck M.D. **ADDRESS** (Street, city, town, state) 41 Southgate Ave Annapolis Md **DATE SIGNED** 1/23/57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1/26/57	Mt Olivet Cemetery	Washington D. C.

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
DATE JAN 28 1957	Wm. J. Fenchs	[illegible] Sons Hyattsville, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

120 **CERTIFICATE OF DEATH** 00153

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A. A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A. A. General

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: West Va — b. COUNTY: Marion
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fairmont
d. STREET ADDRESS: R F D 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Jane — Middle: Cook — Last: Meredith

4. DATE OF DEATH: Month: 1 — Day: 31 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4-24-1916

9. AGE (In years last birthday): 40 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Mannington West Va

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Arthur S. Clayton

14. MOTHER'S MAIDEN NAME: Louise Cook

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT — Address: Mrs Russell Meredith Fairmont W. Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uremia c/u — INTERVAL BETWEEN ONSET AND DEATH: ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Alcoholic Cirrhosis — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-26-, 1957, to 1-31-, 1957, that I last saw the deceased alive on 1-30-57, 19____, and that death occurred at 6 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank M. Shipley M.D. — ADDRESS (Street, city or town, state): 63 College Ave — DATE SIGNED: 1/31/57

PHYSICIAN'S NAME (Type): Frank M Shipley — Annapolis Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal — 22b. DATE THEREOF: 1-31-57 — 22c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemet — 22d. LOCATION (City, town, or county) (State): Fairmont West Va

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR DATE: 1/31/57 — 24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

165

CERTIFICATE OF DEATH

Reg. Dist. No. 00154 58

1. PLACE OF DEATH
a. COUNTY Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland — b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. STREET ADDRESS 1117 Harlem Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Florence Middle Last Moore
4. DATE OF DEATH Month January Day 19 Year 1957

5. SEX Female
6. COLOR OR RACE Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 2-14-78
9. AGE (In years last birthday) 16 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME 2
14. MOTHER'S MAIDEN NAME 2

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 2
17. INFORMANT Address John Moore, Son 1117 Harlem Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Arterio Sclerotic C.V. Disease — INTERVAL BETWEEN ONSET AND DEATH
4424
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Arterial Nephrosclerosis.
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 4-30-, 19 57, to 1-19-, 19 57, that I last saw the deceased alive on 1-19- 19 57, and that death occurred at 12:10 P.M. from the causes and on the date stated above.
ACTUAL SIGNATURE K. Weber M.D. ADDRESS (Street, city or town, state) Crownsville State Hospital DATE SIGNED 1-20-57
PHYSICIAN'S NAME (Type) KONSTANTIN WEBER Crownsville Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 1-23-57
22c. NAME OF CEMETERY OR CREMATORY Antietam
22d. LOCATION (City, town, or county) (State) Balto Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Samuel W Sullivan Jr Balto
24a. REC'D BY REGISTRAR DATE 1-23-57
24b. REGISTRAR'S SIGNATURE E. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

00155

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

166

CERTIFICATE OF DEATH

Items 3,7,11 Film 0209 1-11-57 et

Reg. Dist. No. 24

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

The blue copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death.

1. PLACE OF DEATH

COUNTY ANNE ARUNDEL — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE

LENGTH OF STAY (In this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS PLAZA MANOR CONVALESCENT HOME

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk

STREET ADDRESS (If rural give location) 270 Delk Ct., Dundalk, Maryland

3. NAME OF DECEASED (Type or Print) (First) CLOSES (Middle) ARMSTEAD (Last) MORTON

MORTON ARMSTEAD

4. DATE OF DEATH (Month) Jan (Day) 3 (Year) 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	C	SEPARATED	[redacted]	69 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S.A. Post Office Clerk

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Charlott Co., Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME William C. Morton

14. MOTHER'S MAIDEN NAME Rachael Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. [redacted]

17. INFORMANT & ADDRESS Mr. John Morton - 1714 Laurens St.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) CEREBRO-VASCULAR ACCIDENT

ANTECEDENT CAUSE(S) DUE TO (B) ARTERIOSCLEROSIS

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) GENERAL

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 1956 to Jan 3 1957, that I last saw the deceased alive on Dec 29, 1956, and that death occurred at 12:57 M, from the causes and on the date stated above.

SIGNATURE [signature] M.D. **ADDRESS** (Street, city, town, state) Glen Burnie, Md. **DATE SIGNED** Jan 3, 1957

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1/6/57	Mt. Calvary	Baltimore, Maryland

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
DATE Jan 1957	L. J. Sedlbo	Charles R. Law	802 Madison Avenue

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00156

167

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH
a. COUNTY Ca Co MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Ernie
c. LENGTH OF STAY IN 1b 14yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 108 Georgia Ave N.W.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Md b. COUNTY Ca. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Ernie
d. STREET ADDRESS 108 Georgia Ave N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First William Middle E. Last Oppel

4. DATE OF DEATH Month Jan. Day 13 Year 19 57

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH July 24 1874 9. AGE (In years last birthday) 82 yrs.

IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) a Stable Boy
10b. KIND OF BUSINESS OR INDUSTRY Barrel Fact.
11. BIRTHPLACE (State or foreign country) Baltimore
12 CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME Michael Oppel
14. MOTHER'S MAIDEN NAME Mary Bender

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Mrs Lettie Oppel Address 108 Georgia Ave N.W.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 1 mo.

DUE TO (b) Arteriosclerotic Heart Disease — 5 yrs+

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Benign Prostatic Hypertrophy — 2-3 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 19, 1956, to Jan 13, 1957, that I last saw the deceased alive on Jan 11, 1957, and that death occurred at 6:50 P.M, from the causes and on the date stated above.

ACTUAL SIGNATURE C. Milton Linthicum M.D. ADDRESS (Street, city or town, state) 106 W. Maple Rd. Linthicum Hgts Md DATE SIGNED 1/14/57

PHYSICIAN'S NAME (Type) C. MILTON LINTHICUM

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 1/17/57
22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.
22d. LOCATION (City, Town, or County) (State) Ruxton Baltimore Md

23. FUNERAL DIRECTOR'S SIGNATURE J. Thomas Fox ADDRESS 911 Hollins St (23)
24a. REC'D BY REGISTRAR DATE 1/15/57
24b. REGISTRAR'S SIGNATURE L. J. Dalba

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

121 — 00157 — Reg. Dist. No. 21

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 shall be used as burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
5M 9/55

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md. — b. COUNTY: Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis	c. LENGTH OF STAY IN 1b:	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 19 Wardour Drive		d. STREET ADDRESS: 19 Wardour Drive	e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
James	Lee	Ostrander	1.	17	19 57

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White		Sept. 25, 1956	yrs.	3	23		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Annapolis, Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Donald Richard Ostrander	Frances Ann Dunn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	-	Donald R. Ostrander #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Interstitial pneumonitis — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: William V. Lovitt M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☒ — DATE SIGNED

EXAMINER'S NAME (Type): William V. Lovitt, Jr., M.D. — DEPUTY MEDICAL EXAMINER ☐ — 1/17/57

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	1-18-57	Arlington National	Arlington Virginia

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
John M. Taylor and Sons	Annapolis, Maryland	1/18/57	Wm. J. French

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00158

: 122 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ANNE ARUNDEL GENERAL Hospt

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RIVA
d STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First HOWARD — Middle B. — Last PALMER

4. DATE OF DEATH: Month 1 — Day 8 — Year 1957

5 SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9-29-1879

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TOBACCO FARM

10b. KIND OF BUSINESS OR INDUSTRY: FARMER

11. BIRTHPLACE (State or foreign country): OHIO

12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: LUTHER A. PALMER

14. MOTHER'S MAIDEN NAME: SARAH JANE VISCHER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17 INFORMANT: Address: MRS. ZELLA LEATHERBURY #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac. Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Arteriosclerotic Cardio Vascular Disease — yrs.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12/29, 1956, to 1/8, 1957, that I last saw the deceased alive on 1/7, 1957, and that death occurred at 9:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Maurice F Klawans M.D. ADDRESS (Street, city or town, state): 31 Smithville Av., Annapolis DATE SIGNED: 1/10/57

PHYSICIAN'S NAME (Type): MAURICE F. KLAWANS

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 1-12-57

22c. NAME OF CEMETERY OR CREMATORY: EDWARDS CHAPEL

22d LOCATION (City, town, or county): ANNA polis (State): MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor + Sons ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: 1/15/57

24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00159

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CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn Pk
c. LENGTH OF STAY IN 1b: 9 mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 14-3rd Ave

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn Pk
d. STREET ADDRESS: 14-3rd Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Matilda Middle P Last Glatt

4. DATE OF DEATH: Month Jan Day 30 Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 20, 1873

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): Balto

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: John Miller

14. MOTHER'S MAIDEN NAME: Mary Voge

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Edna E. Dawson Address: 14-3rd Ave Brooklyn Pk

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arterio-sclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 years

U.R.O.D.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Generalized arterio-sclerosis — 2

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour ___ o. m. p. m. Month ___ Day ___ Year 19___

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/28, 1955, to 1/30, 1957, that I last saw the deceased alive on 1/29, 1957, and that death occurred at 5.50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Harry Deibel M.D. ADDRESS (Street, city or town, state): 1226 Hanover St Balto 30 Md DATE SIGNED

PHYSICIAN'S NAME (Type): HARRY DEIBEL, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 2, 1957

22c. NAME OF CEMETERY OR CREMATORY: Westview

22d. LOCATION (City, town, or county) (State): Balto Md

23. FUNERAL DIRECTOR'S SIGNATURE: C. Wallace Evans ADDRESS: 14 E. St. Charles St

24a. REC'D BY REGISTRAR DATE: FEB 4 1957

24b. REGISTRAR'S SIGNATURE: Ida Wilson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No. 00160

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 3 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 506 Munroe Circle

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 506 Munroe Circle
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: R. — Last: Phelps

4. DATE OF DEATH: Month: January — Day: 3, — Year: 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb. 4, 1871

9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework (ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Montgomery Co., Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Isaac N. Shipley

14. MOTHER'S MAIDEN NAME: Marbary J. Pyles

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs. Charles Purdum
Address: 404 Second Ave., SW Glen Burnie, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.
DUE TO
(b):
DUE TO
(c):

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 19 36, to Jan. 3, 19 57, that I last saw the deceased alive on Jan. 2, 19 57, and that death occurred at 3:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James S. Billingslea M.D. — ADDRESS (Street, city or state): 108 Central Ave, Glen Burnie — DATE SIGNED: 1/3/57

PHYSICIAN'S NAME (Type): James S. Billingslea M.D. — Glen Burnie, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Jan. 5/57

22c. NAME OF CEMETERY OR CREMATORY: Meadowridge Mem. Pk.

22d. LOCATION (City, town, or county) (State): Howard Co., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: R. L. Singleton — ADDRESS: Glen Burnie, Md.

24a. REC'D BY REGISTRAR — DATE: Jan 4, 1957

24b. REGISTRAR'S SIGNATURE: L. J. D'Alesio

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No. 00161

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 2mos.20 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jessups
d. STREET ADDRESS: Route #1, Box 269
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Martha — Middle: — Last: Phillips

4. DATE OF DEATH: Month: 1 — Day: 11 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Not given

9. AGE (In years last birthday): 76? yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Not listed

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Robert Dansic

14. MOTHER'S MAIDEN NAME: Beckie Dansic

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service): Unk.

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records — Address: Crownsville State Hospital, Crownsville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH:

331x

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4251

(b) Cerebrovascular Accident

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic cardiovascular disease and Senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/16, 19 56, to 1/11, 19 57, that I last saw the deceased alive on 1/11, 19 57, and that death occurred at 4:45 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McH Mapp M.D. — ADDRESS (Street, city or town, state): Crownsville, Md. — DATE SIGNED: 1/12/57

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Jan 16 1957 — 22c. NAME OF CEMETERY OR CREMATORY: Mt Auburn Cem — 22d. LOCATION (City, town, or county): Balto. — (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm Kate K. Williams — ADDRESS: 522 Edmondson Ave

24a. REC'D BY REGISTRAR — DATE: 1/15/57 — 24b. REGISTRAR'S SIGNATURE: L. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 171

CERTIFICATE OF DEATH

Reg. Dist. No. 00168

1. PLACE OF DEATH
a. COUNTY: Anne Arundel, MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville Md.
c. LENGTH OF STAY IN 1b: 5 mo,
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sanns Nursing Home,

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE: MD.
b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville Md.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Henrietta Middle Lost Poole

4. DATE OF DEATH: Month Jan. Day 1 Year 1957,

5. SEX: F.

6. COLOR OR RACE: W.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov 19 1875

9. AGE (If years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife.

10b. KIND OF BUSINESS OR INDUSTRY: Home.

11. BIRTHPLACE (State or foreign country): Baltimore.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James Hunthel

14. MOTHER'S MAIDEN NAME: Sarah ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) N.K. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Daughter Address: Mrs Manning Severna Park MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial INFarction.
DUE TO
(b): Generalized Arteriosclerosis
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1951, 19..., to Jan 1, 1957, that I last saw the deceased alive on Dec 12, 1956, and that death occurred at 11:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert R Hahn M.D. ADDRESS (Street, city or town, state): Severna Park Md DATE SIGNED: 1-4-57

PHYSICIAN'S NAME (Type): Robert R. Hahn. M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1/5/57

22c. NAME OF CEMETERY OR CREMATORY: Western Cemetery

22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: McCully Funeral Homes 130 E. Fort Ave.

24a. REC'D BY REGISTRAR DATE: JAN 4 19 57

24b. REGISTRAR'S SIGNATURE: A. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00163

172 CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 1320 N. Calhoun Street Vol 4.
d. STREET ADDRESS: Baltimore City
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First David — Middle — Last Powell
4. DATE OF DEATH: Month 1 — Day 17 — Year 1957

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 14, 1902
9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unk.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: John T. Powell
14. MOTHER'S MAIDEN NAME: Not given

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWI
16. SOCIAL SECURITY NO.: Unk.
17. INFORMANT: Hospital Records — Address: Crownsville State Hospital Crownsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Pleural effusion and Pleuritis - right lung
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary Tuberculosis, congestive heart failure and General Paresis of — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): the Insane
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/10, 19 56, to 1/17, 19 57, that I last saw the deceased alive on 1/15, 19 57, and that death occurred at 11:45a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D.
ADDRESS (Street, city or town, state): Crownsville, Md.
DATE SIGNED: 1/17/57
PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D.

22a. BURIAL, ~~CREMATION~~, REMOVAL (Specify)
22b. DATE THEREOF: 1/21/57
22c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
22d. LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. L. Nelson
ADDRESS: 1348 N. Calhoun St.
24b. REC'D BY REGISTRAR DATE: January 19 1957
24b. REGISTRAR'S SIGNATURE: R. W. L. M. Jaynes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00164

173 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH
a. COUNTY: AA — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
c. LENGTH OF STAY IN 1b: YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Mountain Rd.

2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Pasadena
d. STREET ADDRESS: Mountain Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Fred. Middle: C. Last: Reinhardt

4. DATE OF DEATH: Month: 1 Day: 2 Year: 19 57

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2/17/88
9. AGE (In years last birthday): 68 yrs
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret.
10b. KIND OF BUSINESS OR INDUSTRY: Stand. States. Coop.
11 BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unk.
14. MOTHER'S MAIDEN NAME: UNK.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW 1
16. SOCIAL SECURITY NO.: 217 09 9244
17. INFORMANT: Family Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 hours
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from September 10 19 56 to January 2 19 57 that I last saw the deceased alive on January 2, 19 57, and that death occurred at 5 P.M., from the causes and on the date stated above.

ACTUAL [redacted] R. M. McLaughlin M.D. ADDRESS (Street, city or town, state): Pasadena, Md. DATE SIGNED: January 2, 1957

PHYSICIAN'S NAME (Type) R. M. McLaughlin

22a. BURIAL, CREMATION, REMOVAL (Specify): B
22b. DATE THEREOF: 1/5/57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem.
22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: McCully Funeral Homes 130 E. Fort Ave.
24a. REC'D BY REGISTRAR DATE: JAN 4 1957
24b. REGISTRAR'S SIGNATURE: L. J. Kelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

171

Reg. Dist. No. 00165

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FORT GEO G MEADE
c. LENGTH OF STAY IN 1b: 5 MONTHS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: USAH

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SEVERN
d. STREET ADDRESS: 2 WATT AVENUE, BOX 118
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
JERRY	IRVING	RUBIN	JANUARY	7,	1957

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
MALE	CAU		March 14, 1904	52 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SOLDIER, US ARMY	US ARMY	New York	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Simon Rubin	Sarah Storick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT Address
YES			MRS. SEIMA ZEILKIND, 67 DEPPIE PLACE, BERKELEY HTS NEW JERSEY

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Infaret with Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 5 months

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from June, 1955 to 7 Jan, 1957 that I last saw the deceased alive on 5 Jan, 1957, and that death occurred at 1:15 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: John F. McDonnell M.D. — ADDRESS (Street, city or town, state): U. S. ARMY HOSPITAL, FGGM, Md. — DATE SIGNED: 7 Jan 57

PHYSICIAN'S NAME (Type): JOHN F. MCDONNELL

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	9 Jan 57	Old Montefiore Cemetery	Queens County, New York

23. FUNERAL DIRECTOR'S SIGNATURE: [signature] ADDRESS: New York

I J MORRIS, INC, 9701 Church Avenue, Brooklyn,

24a. REC'D BY REGISTRAR DATE: 7 Jan 57 — 24b. REGISTRAR'S SIGNATURE: W.L. SAYLOR, 1ST LT, MSC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

175

Reg. Dist. No. 00166

1. PLACE OF DEATH — a. COUNTY: Anne Arundel — MARYLAND
2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) — a. STATE: Maryland — b. COUNTY: Baltimore City
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 6mos.11 days
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital
d. STREET ADDRESS: 72a E. 20th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: John — Middle: — Last: Scarborough
4. DATE OF DEATH: Month: 1 — Day: 21 — Year: 1957
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 21, 1893
9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Not listed
10b. KIND OF BUSINESS OR INDUSTRY: - - -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: Horace Scarborough
14. MOTHER'S MAIDEN NAME: Mary London

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service): Unk.
16. SOCIAL SECURITY NO.: Unk.
17. INFORMANT: Hospital Records — Address: Crownsville State Hospital, Crownsville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH

422.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/12, 19 56, to 1/21, 1957, that I last saw the deceased alive on 1/21, 19 57, and that death occurred at 10:05a.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D.
ADDRESS (Street, city or town, state): Crownsville, Md.
DATE SIGNED: 1/22/57

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-26-57
22c. NAME OF CEMETERY OR CREMATORY: Mt Auburn.
22d. LOCATION (City, town, or county) (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Geo. S. Kelson
ADDRESS: 1348 N. Calhoun St
24a. RECD BY REGISTRAR / DATE: 1-30
24b. REGISTRAR'S SIGNATURE: H. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00167

123

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A.A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNApolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A.A. GENERAL Hospt.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. — b. COUNTY: AA.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS MD.
d. STREET ADDRESS: RT #2 BOX 16
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MICHAEL Middle PARKER Last SCHWALIER
4. DATE OF DEATH: Month Jan Day 1 Year 1957

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-29-56
9. AGE (If years last birthday) yrs.:
IF UNDER 1 YEAR: Months — Days 3
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: ANDREW M. SCHWALIER
14. MOTHER'S MAIDEN NAME: KATHERINE E. BUTHER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: ANDREW M. SCHWALIER #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchial pneumonia
DUE TO (b): Prematurity
DUE TO (c):

763.5

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 3 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12/29, 1956, to 1/1, 1956, that I last saw the deceased alive on 12/30, 1956, and that death occurred at 4 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph C Sheehan M.D. — ADDRESS (Street, city or town, state): 69 Franklin — DATE SIGNED

PHYSICIAN'S NAME (Type): JOSEPH C. SHEEHAN — annapolis, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-3-57
22c. NAME OF CEMETERY OR CREMATORY: St. MARY'S
22d. LOCATION (City, town, or county) (State): ANNAPOLIS MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Son — ADDRESS: Annapolis MD.
24a. REC'D BY REGISTRAR DATE: 1/4/57
24b. REGISTRAR'S SIGNATURE: Wm. J. French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00168

175

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: a a — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hillsville
c. LENGTH OF STAY IN 1b: 15 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: md — b. COUNTY: a a
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Catonsville
d STREET ADDRESS:
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Walter — Middle Edward — Last Seiske
4. DATE OF DEATH: Month Jan — Day 26 — Year 1957

5 SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan 8 1880
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Homes
11. BIRTHPLACE (State or foreign country): Catonsville md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Frederick a Seiske
14. MOTHER'S MAIDEN NAME: Fishmore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 214350379
17. INFORMANT: Evelyn Hartge — Address: Hillsville md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of bladder — INTERVAL BETWEEN ONSET AND DEATH: 4 years
181X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): E Metastisis to liver
DUE TO
(c): kidneys, lungs etc

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March, 1955 to January 26 1957 that I last saw the deceased alive on 27 January, 1957, and that death occurred at 3:00 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: J D Hendrick M.D. — ADDRESS (Street, city or town, state): Shady Side, Maryland — DATE SIGNED: 1/29/57
PHYSICIAN'S NAME (Type): F D Hendricks — Shady Side, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 1/29/57
22c. NAME OF CEMETERY OR CREMATORY: Loudon Park
22d LOCATION (City, town, or county): Baltimore (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Bunce Hardesty — ADDRESS: Hillsville md
24a REC'D BY REGISTRAR (Date): JAN 29 1957
24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, Pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

[redacted]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00169

177

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): East Port
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 205 Chester Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: A. A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): East Port
d. STREET ADDRESS: 205 Chester Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Alexander Middle — Last Shaw

4. DATE OF DEATH: Month 1 Day 11 Year 1957

5. SEX: Male

6. COLOR OR RACE: Col

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9-10-1872

9. AGE (In years last birthday): 84 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Oysterman

10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): West River, Md

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Josephine Coates — Address: 118 Chester Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH
420.0
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m., 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-2-57, 19____, to 1-11-57, 19____, that I last saw the deceased alive on 1-11-57, 19____, and that death occurred at 3 [illegible] M, from the causes and on the date stated above.

ACTUAL SIGNATURE: C. T. Coates M.D. ADDRESS (Street, city or town, state): C L Cockeysville Md DATE SIGNED: 1-11-57

PHYSICIAN'S NAME (Type): A. T. ALLEN — Emergency Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1-15-57

22c. NAME OF CEMETERY OR CREMATORY: Brewer Hill

22d. LOCATION (City, town, or county) (State): Annapolis, Md

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese II — ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR DATE: 1-14-57

24b. REGISTRAR'S SIGNATURE: Wm J French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

178

CERTIFICATE OF DEATH

00179

Reg. Dist. No. 78

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 4months25days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City
d. STREET ADDRESS: 556 Oxford Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Isaac — Middle: — Last: Sheridan

4. DATE OF DEATH: Month: 1 — Day: 16 — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Not given

9. AGE (In years last birthday): 60? yrs
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unk.

10b. KIND OF BUSINESS OR INDUSTRY: - - -

11. BIRTHPLACE (State or foreign country): Not given

12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: Not given

14. MOTHER'S MAIDEN NAME: Not given

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service): Unk.

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT: Hospital Records — Address: Crownsville State Hospital, Crownsville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac arrest

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Arteriosclerotic cardiovascular disease

DUE TO

(c) Cerebral atrophy

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebro-spinal syphilis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/22, 19 56, to 1/16, 19 57, that I last saw the deceased alive on 1/16, 19 57, and that death occurred at 4:25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.

ADDRESS (Street, city or town, state): Crownsville, Maryland

DATE SIGNED: 1/17/57

PHYSICIAN'S NAME (Type): Ludwig Benedict, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1/21/57

22c. NAME OF CEMETERY OR CREMATORY: National Cemetery

22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Thomas E. Nelson Jr. — ADDRESS: 1323 Eastern Ave. Balto. Md.

24a. REC'D BY REGISTRAR DATE: JAN 25 1957

24b. REGISTRAR'S SIGNATURE: J. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page [illegible] be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00171

Reg. Dist. No. 13

179

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: A A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Linthicum
c. LENGTH OF STAY IN 1b: 16 yr.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 438 Shipley Rd.

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Linthicum Hgts.
d. STREET ADDRESS: 438 Shipley Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Wm Middle Graham Last Sinclair

4. DATE OF DEATH: Month Jan Day 4 Year 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9/28/96

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rigger

10b. KIND OF BUSINESS OR INDUSTRY: Ship -

11. BIRTHPLACE (State or foreign country): South Africa

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Hugh M. Sinclair

14. MOTHER'S MAIDEN NAME: Mary ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 214-03-2078

17. INFORMANT: Christine Sinclair — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio Vascular Disease
422.2
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1956 to 1/4/57, 19___, that I last saw the deceased alive on 1/4/57, 19___, and that death occurred at 10 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Chas. L. Ball Jr. M.D. — ADDRESS (Street, city or town, state): Linthicum Md — DATE SIGNED: 1/4/57

PHYSICIAN'S NAME (Type): Dr. Charles L. Ball, Jr. — Linthicum, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1/8/57

22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cemetery

22d. LOCATION (City, town, or county) (State): Glen Bernie AA Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: McCully Funeral Home — ADDRESS: 130 E. Fort Ave

24a. REC'D BY REGISTRAR DATE: JAN 10 1957

24b. REGISTRAR'S SIGNATURE: R. T. Hedrick

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

124 **CERTIFICATE OF DEATH** 00172

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. NAVAL HOSPITAL, ANNAPOLIS MD

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DAVIDSONVILLE R 1
d. STREET ADDRESS: RT #1 BOX 58A
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Baby Girl; Middle:; Last: SMITH

4. DATE OF DEATH: Month: January; Day: 13; Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 12 JAN 57

9. AGE (In years last birthday): yrs

IF UNDER 1 YEAR: Months: Days: Hours: 7 Min. 14

IF UNDER 24 HRS:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): - - -

10b. KIND OF BUSINESS OR INDUSTRY: - - - -

11. BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Edgar Harold SMITH

14. MOTHER'S MAIDEN NAME: Keiko SUGIYAMA

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: - - -

17. INFORMANT: Address: U.S. Naval Hospital, Annapolis, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Immaturity — INTERVAL BETWEEN ONSET AND DEATH:

77% X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Prematurity

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m; Month; Day; Year 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12 January, 1957, to 13 January 1957, that I last saw the deceased alive on 13 January, 1957, and that death occurred at 715AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Francesco DePaola M.D.

ADDRESS (Street, city or town, state): U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.

DATE SIGNED:

PHYSICIAN'S NAME (Type): Francesco DE PAOLA LT MC USNR

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 1-14-57

22c. NAME OF CEMETERY OR CREMATORY: ANNAPOLIS NECK CEM.

22d. LOCATION (City, town, or county) (State): ANNAPOLIS MD.

23. FUNERAL DIRECTOR'S SIGNATURE: JOHN M. TAYLOR & SON

ADDRESS: ANNAPOLIS MD.

24a. REC'D BY REGISTRAR DATE: 1/15/57

24b. REGISTRAR'S SIGNATURE:

2017232 #1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00173

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH

COUNTY: Anne Arundel — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort Geo. G. Meade

LENGTH OF STAY (In this place): 3 Weeks

HOSPITAL OR INSTITUTION OR STREET ADDRESS: US Army Hospital, Fort George G Meade, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland — COUNTY: Baltimore

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore

STREET ADDRESS (If rural give location): 610 Cathedral Street

3. NAME OF DECEASED (Type or Print): (First) EVA (Middle) MAE (Last) SMITH

4. DATE OF DEATH (Month) (Day) (Year): January 19 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	widowed	July 7, 1911	45 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk Social Security Adm.		Bedford, Indiana	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Elmer Head	Grace Grey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
	[redacted]	Lt. Thomas E. Smith, Finksburg, Md. Rt 1 Box 10

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A): Sarcomatosis, disseminated

ANTECEDENT CAUSE(S) DUE TO (B):

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C):

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED White at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 28 December, 1956, to 19 January, 1957, that I last saw the deceased alive on 19 January, 1957, and that death occurred at 3:00p M, from the causes and on the date stated above.

SIGNATURE [signature] M.D. — **ADDRESS** (Street, city, town, state): US Army Hospital, Fort George G Meade, Md. — **DATE SIGNED**

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	21/1/1957	Druid Ridge Cemetery	Baltimre, Maryland

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
DATE 21 Jan 57	W. L. SAYLOR, 1/Lt MSC	Leonard J. Ruck 5305 Harford Road.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00174

181

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 2months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Catonsville
d. STREET ADDRESS: 14 Shipley Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Isiah — Middle: — Last: Smith

4. DATE OF DEATH: Month: 1 — Day: 20 — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-27-1890 Xxxxxxxx

9. AGE (In years last birthday): XX 66 Yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Cooksville, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Smith

14. MOTHER'S MAIDEN NAME: Mariah Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes — (If yes, give war or dates of service): WWI

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records — Address: Crownsville State Hospital, Crownsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Septicemia — INTERVAL BETWEEN ONSET AND DEATH:

692.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Cavernous Sinus Thrombosis

DUE TO (c): Cellulitis of the face

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11/30, 19 56, to 1/20, 19 57, that I last saw the deceased alive on 1/18, 19 57, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D. — ADDRESS (Street, city or town, state): Crownsville, Md. — DATE SIGNED: 1/21/57

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify) — 22b. DATE THEREOF: 1/24/57 — 22c. NAME OF CEMETERY OR CREMATORY: National Cemetery — 22d. LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE: F. C. Hagelbaum — ADDRESS: Elliott City, Md.

24a. REC'D BY REGISTRAR DATE: JAN 23 1957 — 24b. REGISTRAR'S SIGNATURE: E. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

182

00175

Reg. Dist. No. 28

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 7mos.27days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City
d. STREET ADDRESS: 752 N. Gay Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mamie; Middle: ; Last: Souza

4. DATE OF DEATH: Month: 1; Day: 16; Year: 19 57

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: ~~Not given~~ Aug. 15.

9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Housework

11. BIRTHPLACE (State or foreign country): ~~Not given~~ Chester S.C.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: William Anderson

14. MOTHER'S MAIDEN NAME: Lucy Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unk. (If yes, give war or dates of service): Unk.

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT: Hospital Records — Address: Crownsville State Hospital, Crownsville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypostatic Pneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cerebrovascular accident with right hemiplegia
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertensive cardiovascular disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/13, 19 56, to 1/16, 19 57, that I last saw the deceased alive on 1/16, 19 57, and that death occurred at 11:45a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D.
ADDRESS (Street, city or town, state): Crownsville, Md.
DATE SIGNED: 1/16/57

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/19/57
22c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
22d. LOCATION (City, town, or county) (State): Baltimore City, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Nathan R. Williams
ADDRESS: 322 N. Edmondson Ave

24a. REC'D BY REGISTRAR DATE: 1/18/57
24b. REGISTRAR'S SIGNATURE: L. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

125

Reg. Dist. No. 21 00176

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis, Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DOA Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived — If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gambrills
d. STREET ADDRESS: Defence Highway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle R — Last SPENCER

4. DATE OF DEATH: Month JANUARY — Day 2 — Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 19, 1892

9. AGE (In years last birthday): 64 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: lumber mill

11. BIRTHPLACE (State or foreign country): Carroll, Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jefferson D. Spencer

14. MOTHER'S MAIDEN NAME: Margaret Spencer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
If yes, give war or dates of service: WW I

16. SOCIAL SECURITY NO.: 216-12-6422

17. INFORMANT — Address: Mrs Lora V. O'Dell- Sister- same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fractured Skull, Fracture Cervical Spine,
DUE TO (b): Crushing injuries to chest
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Compound Fracture of Right Tibia and Fibula

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): was struck by auto while walking on road

20c. TIME OF INJURY — Hour: 3:25 — a.m. ☐ p.m. ☒ — Month, Day, Year: Jan. 2 57

20d. INJURY OCCURRED — While at work ☐ — Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Rt 450

20f. (City or town) (County) (State): Gambrills, Anne Arundel, Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D.
EXAMINER'S NAME (Type): Elmer J. Linhardt M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: January 2, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Jan. 4, 1957

22c. NAME OF CEMETERY OR CREMATORY: National Cemetery

22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: [signature]
ADDRESS: HOPPING FUNERAL HOME Annapolis, Md.

24a. RECD BY REGISTRAR — DATE: JAN 7 1957

24b. REGISTRAR'S SIGNATURE: [signature]

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

126

CERTIFICATE OF DEATH

00177

Reg. Dist. No. 21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland — b. COUNTY: A. A. Co
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis — c. LENGTH OF STAY IN 1b:	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural (Annapolis) Mulberry Hill
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A. A. General Hosp.	d. STREET ADDRESS: Rte. 4 Box 3 — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First: Perry — Middle: — Last: Stansburr	4. DATE OF DEATH: Month: 1 — Day: 17 — Year: 1957
5. SEX: Male — 6. COLOR OR RACE: Col. — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: 4-16-1891 — 9. AGE (In years last birthday): 65 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cement Finisher — 10b. KIND OF BUSINESS OR INDUSTRY: North Severn Public Sch. — 11. BIRTHPLACE (State or foreign country): Maryland — 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Perry Stansbury — 14. MOTHER'S MAIDEN NAME: Harriett Harriod	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown): Yes — (If yes, give war or dates of service): W.W.I — 16. SOCIAL SECURITY NO: 214-05-2350 — 17. INFORMANT: Norman Stansbury — Address: Mulberry Hills, Md	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Hypertensive arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

DUE TO (b): 4 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month — Day — Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/12, 19 52, to 1/17, 19 57, that I last saw the deceased alive on 1/17, 19 57, and that death occurred at 10:25 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John L. Hedrick M.D. — ADDRESS (Street, city or town, state): 90 Cathedral St. Annapolis, Md. — DATE SIGNED: 1/18/57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: 1-21-57	22c. NAME OF CEMETERY OR CREMATORY: Broad Neck	22d. LOCATION (City, town, or county) (State): Skidmore, Md	
23. FUNERAL DIRECTOR'S SIGNATURE: William Reese	ADDRESS: D-Annapolis, Md	24a. RECD BY REGISTRAR DATE: JAN 21 1957	24b. REGISTRAR'S SIGNATURE: Wm. J. French	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00178

183 **CERTIFICATE OF DEATH** Reg. Dist. No. 25

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park
c. LENGTH OF STAY IN 1b 15 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11 3rd Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD b. COUNTY A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park
d. STREET ADDRESS 11 3rd Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First: Stephen Middle: Lost: Synowski
4. DATE OF DEATH Month: Jan Day: 4 Year: 1957

5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Oct 15, 1876
9. AGE (In years last birthday) 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sugar Boiler
10b. KIND OF BUSINESS OR INDUSTRY Amer Sugar
11. BIRTHPLACE (State or foreign country) Austria
12. CITIZEN OF WHAT COUNTRY? U S.

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: Henry Synowski 11 3rd Ave. (25)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Hypertensive Cardiovascular Disease
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 15, 1956 to Jan. 4, 1957 that I last saw the deceased alive on 1/3/57 19__, and that death occurred at 8:00 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE Samuel Rubin M.D. ADDRESS (Street, city or town, state) 203 Potapsco Ave Balto 25 Md DATE SIGNED
PHYSICIAN'S NAME (Type) SAMUEL RUBIN MD Baltimore Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Jan. 7, 1957
22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cy
22d. LOCATION (City, town, or county) (State) Anne Arundel Co Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS [illegible] Hwy Glen Burnie
24a. REC'D BY REGISTRAR DATE JUN 9 1957
24b REGISTRAR'S SIGNATURE Ida M. Hutson D

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 7,13,14, 21m-21o 1-29-57 et

127 CERTIFICATE OF DEATH

00179

Reg. Dist. No. .....

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The [illegible] copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH

COUNTY Anne Arundel — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis — LENGTH OF STAY (In this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS A.H. General

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE — COUNTY

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson Maryland

STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) John (Middle) (Last) Taylor

4. DATE OF DEATH (Month) JAN. (Day) 14 (Year) 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min.
M	White	Separated		71 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Balt. City Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Fannie Bonnett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-12-4113

17. INFORMANT & ADDRESS Fanny Bonnett

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (A) Acute Pulmonary Edema & Uremia — 36 hrs.

ANTECEDENT CAUSE(S) DUE TO (B) Cerebral Vascular Accident — 30 Yrs.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Arteriosclerosis, generalized

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) — 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. — 21e. INJURY OCCURRED While at work ☐ Not while at work ☐ — 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 13, 1957 to Jan. 14, 1957, that I last saw the deceased alive on Jan. 13, 1957, and that death occurred at 2:30 A.M., from the causes and on the date stated above.

SIGNATURE Frank M. Shipley, M.D. — ADDRESS (Street, city, town, state) 63 College Ave. Annapolis — DATE SIGNED 1/15/57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1/16/57	Union Memorial	Balto. Co. Md.

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
DATE 1/22/57	[signature]	[signature]	[illegible]

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00180

CERTIFICATE OF DEATH

Reg. Dist. No. 27

184

1. PLACE OF DEATH

COUNTY Anne Arundel — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Geroge G. Meade

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Army Hospital

2. [redacted]

STATE Maryland COUNTY —

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Baltimore

STREET ADDRESS (If rural give location) 3012 Hanlon Avenue

3. NAME OF DECEASED (Type or Print) (First) AMELIA (Middle) MARIA (Last) THOMAS

4. DATE OF DEATH (Month) January (Day) 26 (Year) 19 57

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	Negro	Single	25 January 1957	yrs.		12 / 26

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James William Thomas	Amelia Maria Kelly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	None	Mother, 3012 Hanlon Avenue, Baltimore, Md.

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE	(A) Anoxia Anoxia	12 hrs 26 min ~~12 hrs 26 min~~
ANTECEDENT CAUSE(S) DUE TO	(B) Atelectasis Atelectasis	12 hrs 26 min
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Atresia of rectum?? Congenital heart disease Atresia of rectum ?? Congenital Heart Disease	12 Hrs 26 min

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 25 Jan., 19 57, to 26 Jan., 19 57, that I last saw the deceased alive on 26 Jan., 19 57, and that death occurred at 11:35 PM, from the causes and on the date stated above.

SIGNATURE Richard N. McGuane, CAPT, MC. M.D. — ADDRESS (Street, city, town, state) 2101-1 St, USAH Ft Meade Md — DATE SIGNED 26 Jan 57

Richard N. McGuane

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1 Feb 57	Baltimore National Cemertery	Baltimore, Md.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
28 Jan 57	W.L. SAYLOR, 1ST LT, MSC	ARLINGTON S. PHILLIPS, Baltimore, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00181

128

CERTIFICATE OF DEATH

Reg. Dist. No. 21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Marylend — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 48 Randall Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: J. — Last: Thompson

4. DATE OF DEATH: Month: January — Day: 12 — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: November 5, 1897

9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: US Gov.

11. BIRTHPLACE (State or foreign country): Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Thompson

14. MOTHER'S MAIDEN NAME: Mary M. Cranford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: none

17. INFORMANT: William J. Thompson Jr. Son Address: Same as # 2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 3 hr.

331 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Cerebral Hemorrhage — 3 hr

DUE TO (c): Hypertension - — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. —19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/11/57, 19 57 to 1/12/57, 19 ____, that I last saw the deceased alive on 1/12/57, 19 ____, and that death occurred at 3:32 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank M. Shipley M.D. — ADDRESS (Street, city or town, state): 63 College Ave. Annapolis — DATE SIGNED: 1/14/57

PHYSICIAN'S NAME (Type): Frank M. Shipley MD — 63 College Ave Annapolis, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1-15-57

22c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff Cemetery

22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: HOPPING FUNERAL HOME — ADDRESS: Annapolis Md.

24a. REC'D BY REGISTRAR, DATE

24b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

: 185

CERTIFICATE OF DEATH

Reg. Dist. No. 00182 33

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arnold
c. LENGTH OF STAY IN 1b: 4 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Grand View Ave.

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arnold
d. STREET ADDRESS: Grand View Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Guy — Middle Steele — Last Tregoe Sr.

4. DATE OF DEATH: Month Jan. — Day 15, — Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 5, 1901

9. AGE (In years last birthday): 55 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Accountant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore City

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William E. Tregoe

14. MOTHER'S MAIDEN NAME: Mary Linda Seymour

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 215-07-5412

17. INFORMANT — Address: Guy S. Tregoe Jr/Reisterstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Malignant Tumor of Brain — INTERVAL BETWEEN ONSET AND DEATH: 8 Mos.
DUE TO
193X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 19, 1956 to January 16, 1957, that I last saw the deceased alive on January 13, 1957, and that death occurred at 10:45 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Maurice F. Klawans, M.D. — ADDRESS (Street, city or town, state): 315 Smithy Ave. Cw., Annapolis, Md. — DATE SIGNED: 1/16/57

PHYSICIAN'S NAME (Type): MAURICE F. KLAWANS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1-19-57

22c. NAME OF CEMETERY OR CREMATORY: Evergreen Memorial Garden.

22d. LOCATION (City, town, or county) (State): Finksburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: J. F. Eline & Sons, Reisterstown, Md.

24a. REC'D BY REGISTRAR — DATE: 1-16-57

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 7[illegible] after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00183

; 186

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY A.A. MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Md. b. COUNTY A.A.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pines on Severn Arnold Md. c. LENGTH OF STAY IN 1b 4 yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pines on Severn. Arnold

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Path-Old River Rd

d. STREET ADDRESS Spring Path - Old River Rd

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: Robert Middle: Benson Last: Turner.

4. DATE OF DEATH Month: Jan. Day: 27 Year: 1957.

5. SEX M.

6. COLOR OR RACE W

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH March 5, 1899 (1899)

9. AGE (In years last birthday) 67 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Architect.

10b. KIND OF BUSINESS OR INDUSTRY Building.

11. BIRTHPLACE (State or foreign country) Baltimore Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Leonidas G. Turner.

14. MOTHER'S MAIDEN NAME Amelia Archer.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) S (If yes, give war or dates of service) Army 1917-1919

16. SOCIAL SECURITY NO

17. INFORMANT Address: wife - Mrs Turner - Pines on Severn

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH

162 x

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1955, 19, to Jan. 19 57, that I last saw the deceased alive on Jan. 19 57, and that death occurred at 3:25 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Robert R Hahn M.D. ADDRESS (Street, city or town, state) Severna Park, Md. DATE SIGNED 1-27-57

PHYSICIAN'S NAME (Type) Robert R. HAHN. M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 1-30-57

22c. NAME OF CEMETERY OR CREMATORY Arlington Memorial

22d. LOCATION (City, town, or county) Arlington (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE John M Taylor Sons ADDRESS Annapolis, Md.

24a. REC'D BY REGISTRAR DATE 1/29/57

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00184

129 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Anne Arundel — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis

c. LENGTH OF STAY IN 1b 1 mo

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE Md — b. COUNTY A. A.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print) First: EVORA Middle: — Last: Tydings

4. DATE OF DEATH Month: Jan. Day: 27 Year: 1957

5. SEX: F

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/22/27

9. AGE (In years last birthday): 29 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Sudley Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: [illegible]

14. MOTHER'S MAIDEN NAME: [illegible]

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217 34 4744

17. INFORMANT: Wesley Tydings Address: [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral aneurysm type

DUE TO
(b): Ruptured aneurysm of middle cerebral artery

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-10-57 19__ to 1-27-57 19__, that I last saw the deceased alive on 1-23-57 19__, and that death occurred at 1:45 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A. T. Allen M.D.

ADDRESS (Street, city or town, state): 62 Cathedral St, Annapolis, Md

DATE SIGNED

PHYSICIAN'S NAME (Type): A. T. ALLEN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1/27/57

22c. NAME OF CEMETERY OR CREMATORY: Chapel

22d LOCATION (City, town, or county) (State): West River, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Brocato Funeral Home ADDRESS: Edgewater Md

24a. REC'D BY REGISTRAR DATE 1/29/57

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00185

187

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
c. LENGTH OF STAY IN 1b 10months 20days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE Maryland b. COUNTY Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston
d. STREET ADDRESS Rt. #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Booker Middle Last Venable
4. DATE OF DEATH Month 1 Day 18 Year 1957

5. SEX Male
6. COLOR OR RACE Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Not given
9. AGE (In years last birthday) 79? yrs.
IF UNDER 1 YEAR Months — Days —
IF UNDER 24 HRS. Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown
10b. KIND OF BUSINESS OR INDUSTRY - - - -
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME James Red
14. MOTHER'S MAIDEN NAME Jane Red

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) - - -
16. SOCIAL SECURITY NO. Unk.
17. INFORMANT Hospital Records Address Crownsville State Hospital Crownsville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b) Senility with

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c) Diverticulitis Uremia

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Heart Disease Syphilis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/10, 1956, to 1/18, 1957, that I last saw the deceased alive on 1/18, 1957, and that death occurred at 7:00a.M, from the causes and on the date stated above.

ACTUAL SIGNATURE Lionel McHenry Mapp M.D.
ADDRESS (Street, city or town, state) Crownsville, Md.
DATE SIGNED 1/18/57

PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.

22a. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify)
22b. DATE THEREOF 1-25-57
22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary
22d. LOCATION (City, town, or county) (State) Anne Arundel Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE E. C. Wilson
ADDRESS 1008 Druid Park Dr. Balto 17 Md.
24a. REC'D BY REGISTRAR DATE JAN 28 1957
24b REGISTRAR'S SIGNATURE A. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00186

130 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TRACYS Landing
c. LENGTH OF STAY IN 1b 50 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Maryland b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tracey's Landing
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First JAMES Middle Last WALLACE

4. DATE OF DEATH Month January Day 2 Year 19 57

5. SEX Male

6. COLOR OR RACE Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH July 1 1904

9. AGE (In years last birthday) 52 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming

10b. KIND OF BUSINESS OR INDUSTRY Tobacco

11. BIRTHPLACE (State or foreign country) Ealy Haven Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Edward Wallace

14. MOTHER'S MAIDEN NAME Essie Griffin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. 216308483

17. INFORMANT Address Henrietta Wallace Tracys Landing Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stab Wound of Chest — INTERVAL BETWEEN ONSET AND DEATH

977X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Stabbed during altercation.

20c. TIME OF INJURY Hour 6:45 p. m. Month, Day, Year 1/2 1957

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) Tracey's Landing (County) A.A.Co. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined cause ☐.

ACTUAL SIGNATURE Paul F. Guerin M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED 1/3/57

EXAMINER'S NAME (Type) Paul F. Guerin, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 1/6/57

22c. NAME OF CEMETERY OR CREMATORY Union Chapel

22d. LOCATION (City, town, or county) (State) Mokeyvee + Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Bernard Hardesty Gibsville Md

24a. REC'D BY REGISTRAR DATE 1/10/57

24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for [illegible] files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

VS A15ME(S)
5M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filled within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00187

CERTIFICATE OF DEATH

188

Reg. Dist. No. 24

1. PLACE OF DEATH

COUNTY 1 A. MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn

LENGTH OF STAY (in this place) 4 YRS

HOSPITAL OR INSTITUTION OR STREET ADDRESS Box 366 A

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Md COUNTY AA

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn

STREET ADDRESS (If rural give location) Box 366 A, Quarter Field Rd.

3. NAME OF DECEASED (Type or Print) (First) NINA (Middle) C (Last) WATT

4. DATE OF DEATH (Month) 1 (Day) 17 (Year) 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
F	W	M.	Oct 17, 1885	71 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Switzerland	U.S.A.

13. FATHER'S NAME Michael Gauch

14. MOTHER'S MAIDEN NAME Katharina Furrer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	None	Mr Robert Watt, Same as 2

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Lymphosarcoma — INTERVAL BETWEEN ONSET AND DEATH 12 mos.

ANTECEDENT CAUSE(S) DUE TO (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1954, to Jan 17, 1957, that I last saw the deceased alive on Jan 5, 1957, and that death occurred at 10:10 A.M., from the causes and on the date stated above.

SIGNATURE C. S. MacDonald M.D. M.D. ADDRESS (Street, city, town, state) Glen Burnie, Md DATE SIGNED 1-17-57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Cremation	1/17/57	Loudon Park	Balto., Md

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
	L. J. Dallap	Hopping & Kirkley, Glen Burnie Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00188

: 189 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY A.A. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DRURY
c. LENGTH OF STAY IN 1b 30 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DRURY
d. STREET ADDRESS 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First MORGAN Middle BIRKHEAD Last WAYSON

4. DATE OF DEATH Month 1 Day 2 Year 1957

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 3/12/85
9. AGE (In years last birthday) 71 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant owner
10b. KIND OF BUSINESS OR INDUSTRY Restaurant
11. BIRTHPLACE (State or foreign country) Sudley Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME MORGAN M WAYSON
14. MOTHER'S MAIDEN NAME MARY ELLEN BIRCKHEAD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 216326669
17. INFORMANT Address KATHERINE PADGETT, Lothian Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) generalized arteriosclerosis
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. cl. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 6, 1956 to Jan 2, 1957, that I last saw the deceased alive on Jan 1, 1957, and that death occurred at ____M, from the causes and on the date stated above.

ACTUAL SIGNATURE Emily H. Wilson M.D. ADDRESS (Street, city or town, state) Lothian, Md DATE SIGNED 1-3-57

NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 1/5/57
22c. NAME OF CEMETERY OR CREMATORY Christ Church
22d. LOCATION (City, town, or county) Owensville (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE Bernard Hardesty ADDRESS Gelesville Md
24a. REC'D BY REGISTRAR DATE 1/10/57
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Welsh

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00189

131

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY: AA MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis — c. LENGTH OF STAY IN 1b:	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn 3 vol-4
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel Gen. Hosp.	d. STREET ADDRESS: 3941 Brooklyn Ave. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: John — Middle: A. — Last: Welsh	4. DATE OF DEATH: Month 1, Day 17, Year 1957

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min
M	W	Widowed	Aug. 6, 1881	75 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	City of Balto.	Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No		Thomas Welsh	Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple lung abscess — 2 wks.

521X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Coronary artery sclerosis, severe

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH) (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/15, 1957, to 1/17, 1957, that I last saw the deceased alive on 1/17, 1957, and that death occurred at 2 p M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John C. Anderson M.D. — ADDRESS (Street, city or town, state): 90 Cathedral, Annapolis Md. — DATE SIGNED: 1/18/57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	1/21/57	Holy Cross Cem.	Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
McCully Funeral Homes 130 E. Fort Ave.	DATE JAN 21 1957	Wm. J. French

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Filmed [illegible] et

190

CERTIFICATE OF DEATH

00190

Reg. Dist. No. 28

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 4 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sparks, Md
d. STREET ADDRESS: Cockeysville Baltimore Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mamie — Middle: — Last: White

4. DATE OF DEATH: Month: January — Day: 19 — Year: 1957

5. SEX: female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-17-55

9. AGE (In years last birthday): 1 2 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: Millie White (Montgomery)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Increased intracranial pressure
344 x
DUE TO (b): Hydrocephaly
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Emaciation

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-1-56 to 1-19-57, that I last saw the deceased alive on 1-19-57, and that death occurred at 6:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: K. Weber M.D.
ADDRESS (Street, city or town, state): Crownsville State Hosp, Maryland
DATE SIGNED: 1-20-57
PHYSICIAN'S NAME (Type): KONSTANTIN WEBER

22a. BURIAL, CREMATION, REMOVAL (Specify): Buried
22b. DATE THEREOF: 1/24/57
22c. NAME OF CEMETERY OR CREMATORY: Wilson
22d. LOCATION (City, town, or county) (State): Williamsburg Co. S.C.

23. FUNERAL DIRECTOR'S SIGNATURE: William L. Latimer
ADDRESS: 1701 McCulloh St Balto, Md.

24a. REC'D BY REGISTRAR: JAN 22
DATE

24b. REGISTRAR'S SIGNATURE: L. McJoyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00191

Reg. Dist. No. 191

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jessups
c. LENGTH OF STAY IN 1b: Few seconds
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 2000 feet east of route 175 Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Fort Meade
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Hugh Middle E. Last Wilson

4. DATE OF DEATH: Month January Day 21st Year 19 57

5. SEX: M.

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7/9/31

9. AGE (In years last birthday): 25 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sergeant in the U.S. Army

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Verbana, Alabama

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: Irene Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes at present

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Fort Meade's Reords.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fracture of skull — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

923X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Automobile hit a post and turned over

20c. TIME OF INJURY Hour 4.55 a. m. p. m. Month, Day, Year 1/21/57 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Route 6 Md,

20f. (City or town) Jessups, (County) A.A. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gustave H. Faubert M.D. M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 1/21/57

EXAMINER'S NAME (Type): Gustave H. Faubert M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF 1/28/57

22c. NAME OF CEMETERY OR CREMATORY: Morning Star

22d. LOCATION (City, town, or county): Verbena (State) Alabama

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Arlington S. Phillips, 1808 N. Monroe St. Baltimore, Md

24a. REC'D BY REGISTRAR DATE 21 Jan 57

24b. REGISTRAR'S SIGNATURE: W.L. SAYLOR, 1/Lt MSC

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

; 192 **CERTIFICATE OF DEATH**

00192

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DEALE
c. LENGTH OF STAY IN 1b 60 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD — b. COUNTY A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DEALE
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First WILLIAM Middle BRYSON Last Wood

4. DATE OF DEATH Month 1 Day 2 Year 1957

5. SEX MALE — 6. COLOR OR RACE White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH Sept 24 1890 — 9. AGE (In years last birthday) 66 yrs. — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter — 10b. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (State or foreign country) Churchton Md. — 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Richard F. Wood — 14. MOTHER'S MAIDEN NAME Caroline E. SIMMONS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO — (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. 218035023 — 17. INFORMANT Address Lloyd F. Wood, DEALE MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemmhage — INTERVAL BETWEEN ONSET AND DEATH

332x

DUE TO (b) hypertension

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) generalized arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 — 20d. INJURY OCCURRED White at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5-20 19 55, to Jan 2 19 57, that I last saw the deceased alive on Dec 28 19 56, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE Emily H. Wilson M.D. — ADDRESS (Street, city or town, state) Lothian, Md — DATE SIGNED 1-3-57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial — 22b. DATE THEREOF 1/4/57 — 22c. NAME OF CEMETERY OR CREMATORY St JAMES — 22d. LOCATION (City, town, or county) (State) TRACYS Md

23. FUNERAL DIRECTOR'S SIGNATURE Bernard Harkins — ADDRESS Halwells Md — 24a. REC'D BY REGISTRAR DATE 1/10/57 — 24b. REGISTRAR'S SIGNATURE U. Council

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55